FIFTH EDITION

HEALTH INSURANCE *and* MANAGED CARE

What They Are and How They Work

PETER R. KONGSTVEDT

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Preface

This fifth edition of *Health Insurance and Managed Care: What They Are and How They Work* is significantly changed and updated from the fourth edition. Some high-level descriptions of what is new and what has changed in this edition are found in the "New to This Edition" section that follows this Preface. First, however, it is necessary to point out the biggest change affecting every chapter of both the fourth and fifth editions remains The Patient Protection and Affordable Care Act (ACA) of 2010. The ACA is addressed specifically in Chapter 8 and is addressed throughout the entire text as necessary. Some chapters are significantly affected due to changes involving the ACA resulting mostly, but not entirely, from political turmoil since the last edition was published.

The political turmoil around the ACA is the result of changes in control of the House of Representatives, followed by the Senate, and finally the White House that took place between 2010 and 2018. The political party that came into power after 2012 and held it until the elections of 2018, had vowed to "repeal and replace" the ACA, but ultimately was unable to do so…by only a very thin margin. As of late-2018 when this was written, failure to repeal the ACA did not leave Congress and the Administration without recourse, and multiple funding cuts, nonenforcement of certain provisions, and repeal of a few provisions had steadily changed how the ACA affects the health insurance and managed care sector. How the change in control of the House in 2019 will affect the ACA is unknown as this is being written, as is the impact of a late 2018 ruling by a single federal judge invalidating the entire ACA, a ruling that many believe will not stand but that has not been resolved by the time final manuscript was submitted.

But there is nothing new about change. Change is a constant, and whenever you hear someone complain about how the healthcare system in the United States is undergoing turbulent times, you should recognize that it has been in a near-constant state of turbulence for close to a century. As one acquaintance of mine remarked, "Health care is in permanent white water." Wishing we could return to the calm and placid times in the past is the same as wishing we could return to the world of *Leave It to Beaver*; both are fiction and never actually existed.*

The causes of this ongoing turbulence also change, and not just as the result of new laws and regulations. Health costs keep rising, but where once that trend was due primarily to overutilization, it now reflects a great many factors, including and especially pricing, but also advances in technology, organizational realignments, and changing demographics and consumer demands. The industry's dynamic nature is one of the reasons that health insurance and managed care are now so difficult to distinguish from each other, to the degree any

* The second fantasy—that of living in the world of a 1950s sitcom—does, however, make for a wonderful movie titled Pleasantville (1998, New Line Cinema), starring Tobey McGuire, Reese Witherspoon, William H. Macy, Jeff Daniels, Joan Allen, and among many others, the terrific Don Knotts in one of his last performances.

distinction exists. It is also the reason for this text, and the reason you are reading it.

Changes to the ACA are far from over, and changes continue to take place outside the ACA such as new laws, new regulations, new plan designs, new payment methodologies, and new means of managing utilization and quality. It is increasingly challenging to keep the overall size of this text down, even with this book's expansion in size. The only way I have found to address this issue is to focus on the most important aspects, and to keep most descriptions at about the same level, with a few exceptions. Even so, it contains enough detail so that readers who have no knowledge of how health insurance and managed care work will at times feel overwhelmed with it. In contrast, readers who are veterans of the industry will be struck by how much has been left out. If that second group of readers wants more detail, they can find it in this text's older big sister, *The Essentials of Managed Health Care, Sixth Edition*, also published by Jones & Bartlett Learning, and from additional sources such as those that I have provided in the Keeping Current section. Those sources listed are also good resources for staying current, because the reader must always be aware that despite my best efforts, some things described in this book will have changed by the time you are reading it.

While health insurance and managed care might change, the main goal of this text does not. Its purpose is very simple—to provide you with a broad understanding of how health insurance and managed care work in the real world, and to help you perform better in your own work. If not right away, then at some point down the line. Most rewarding, some of you will contribute to the future evolution of this dynamic industry.

Peter Reid Kongstvedt
McLean, Virginia

New to This Edition

What makes this edition different from previous editions? For one thing, it is quite a bit larger—by close to 25%, at least by word count. Each chapter has also been updated, with some requiring a more substantial update than others. There is too much new material to describe fully here. To do so would essentially rewrite the book, so what follows is a very high-level description of some of the more important changes.

Prologue: Moral Hazard

This is entirely new to this book, though an earlier version appears in *The Essentials of Managed Health Care, Sixth Edition* from which it was adapted. Moral hazard is an economics term that applies with particular force in health insurance and managed care, though it can affect some other industries as well such as banking. Moral hazard is always affecting health insurance, however, and understanding it will help you better understand at least some of the reasons things are the way they are. One other thing: The words "moral" and "hazard" do not mean what you probably think they mean.

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

This chapter, co-written with Peter Fox, is the least changed chapter in the book. Obviously, events that occurred after the prior edition was published are now included, but some other historical events have been added and/or clarified.

Chapter 2: Health Benefits Coverage and Types of Health Plans

This chapter has been updated, but its general structure is similar to that found in the prior edition. It has several interrelated areas of focus: what health benefits plans are, including the basic components of any health benefits plan; the sources of health benefits coverage; the concept of risk for medical costs and where it resides; and the many different types of payers that we generally think of when we think of health insurance and managed care. This chapter is not an exercise in hair-splitting because many or most of the concepts brought out in this chapter have an impact on the industry and on you, whether or not you are aware of it.

Chapter 3: The Provider Network

Chapter 3 has the distinction of being the only chapter that is smaller than the one in the prior edition, though only a bit smaller. This is not because the topics involved with a provider network have gotten simpler—they haven't—but because I tried to be more efficient in how I approached the subject matter. There is new

material, including better descriptions of the many ways providers and patients may interact, the way providers and payers may interact, the impact of new or rearranged provider organizational models, and a more useful description of the structural elements of some integrated delivery systems and accountable care organizations.

We have also seen some new dynamics develop around some older types of provider organization such as hospital employment of physicians and the expansion of hospital-based physicians generally. Like the prior edition, this chapter focuses only on provider networks and not on how providers are paid beyond noting some relationships between the two topics as needed. This reflects better how the world actually works, and it keeps the issue of money where it belongs—as a distinct issue requiring the focused descriptions and discussion it deserves.

Chapter 4: Provider Payment

This is one of the chapters that experienced a lot of expansion and change. It contains more detail than what is found in most of the other chapters. The level of detail is no more granular, however; there is just so much more of it. Unlike all other nations on earth, the U.S. healthcare system uses about eleventy-eight zillion different payment strategies and methodologies, and there are an equal number of variations for each one of them. We have created some new approaches through laws and regulations, but we continually create new ways of paying for healthcare goods and services regardless. We also sometimes put a new label on some older methodologies after making a few changes. Not only that, we sometimes put a new label on…well, sometimes nobody can quite agree on that part, we all seem to agree on the label and that it is important.

Even at a high level, addressing the payment methods long used as well as some of the new methods that are in use takes a lot room, making this chapter the second longest in the book (not counting the Glossary). In the case of payment (and as discussed in this text, the proper term is payment, not reimbursement), there is one more reason to describe some of the more common ways we pay for health care, and it is summed up by the singer/songwriter Randy Newman: "It's money that matters, in the USA."*

Chapter 5: Utilization Management, Quality Management, and Accreditation

Another substantially expanded chapter, this chapter still has the basic elements used for the management of utilization and quality, including the related functions of disease and case management, and accreditation that is closely related to quality. Other updates to this chapter include managing utilization in special populations, such as people with multiple chronic conditions, and transition management related to the transition from inpatient to outpatient care.

Payers do not provide health care and cannot tell a physician or hospital what they can or cannot do, only what the health plan will pay for as a covered benefit. For that reason, the role of benefits design has been expanded upon because it factors in so heavily. That, by the way, is not meant to imply that coverage determinations cannot affect how and what

* Randy Newman, "It's Money That Matters" from Land of Dreams, ℗© 1988 Reprise Records.

medical care is provided; it does mean that payers manage the benefits, including through these activities.

The discussion about medical necessity and its impact on benefits coverage has been expanded, as has the description of the use of evidence-based clinical guidelines for coverage determinations. Management of the prescription drug benefit is also evolving as specialty pharmaceuticals grow in importance and cost.

Chapter 6: Sales, Governance, and Administration

Chapter 6 is the largest chapter in the book, and it is the second most updated in terms of expansion and changes. Some of this is due in part to changes in the ACA, and how people access coverage through state-level health insurance exchanges, as well as other changes in laws and regulations affecting payer operations.

New material covers operational aspects that have evolved in just the brief time between the last edition of this book and this one, including a major rewrite of the sections on marketing and sales, and distribution channels. Other aspects have been rewritten for clarity and to make them more compact to make room for new material. The major functional areas have been given their due. It is a large chapter and all sections have been updated and brought to the same relative level of information.

Chapter 7: Medicare Advantage and Managed Medicaid

This chapter has been rewritten almost entirely. It now contains entirely new material on Medicare Part D, the drug benefit and the plans that offer it, and Medicare Advantage (MA). In particular, the chapter now contains descriptions of topics that were only mentioned in the prior edition such as the complex way that MA plans are paid, how payment and performance are adjusted for the level of illness for each individual enrolled member, how MA plan performance is measured and the impact it has on payment and market access, and much more.

The sections on managed Medicaid have likewise been expanded with new material, including better descriptions of the various waivers that states must obtain to contract with private managed Medicaid plans, eligibility issues, Medicaid expansion under the ACA (in some but not all states), and programs such as the State Children's Health Insurance Program, or SCHIP, and long-term care services. Oversight and regulation of MA and managed Medicaid plans have also been expanded.

Chapter 8: Laws and Regulations in Health Insurance and Managed Care

Chapter 8, written by attorney Tom Wilder, has been updated in many ways, but it has changed the least compared to the prior edition. This is because most of the major state and federal laws and regulations affecting payers have been in place for quite a while. But in addition to providing an excellent summary of the key elements of the ACA affecting health benefits plans, recent changes are addressed.

Glossary

The Glossary is large; nearly 1000 words, phrases, or acronyms, which is larger than

its already-large predecessor. New words and phrases have appeared or gone into common usage, while a (very) few others have become newly obsolete. The addition of those new words and phrases accounts for most of the Glossary's expansion, but other changes include updates and clarifications of some of the definitions, spelling out many of the acronyms that prior versions did not include, expansion of some definitions to include new meanings and uses of older terms, and a few terms created and used almost solely by the federal government.

Is That All?

Of course not. This breakdown provides only a glimpse of the overall revisions, updates, and new material in this edition. The health insurance and managed care industry is always undergoing change, and nothing has slowed the rate change since the previous edition's publication. Said another way, changes and updates to this text are equal to the changes in the industry, which have been massive. But if I have done my job right, the new content should all fit together once again. For a little while, at least.

Acknowledgments

While specifically naming all of the people who helped with this text would double its size, I would like to thank many colleagues, clients, and friends in the health insurance, managed care, hospital, and pharmaceutical industries; and in the physician, consulting, and law professions with whom I have had the pleasure of working beside over the years. Likewise, I thank my students and acknowledge their contributions to keeping me on my game. I also want to give sincere thanks to the many readers of previous editions of this text for their support, kind words, observations, and suggestions that have contributed to improvements over the years. Acknowledging the contributions of others does not, however, mean that any of them contributed to any errors or misstatements; those are solely mine.

About the Author

Dr. Peter Kongstvedt is a highly regarded national authority on the healthcare industry with particular expertise in health insurance and managed health care. He is principal of the P. R. Kongstvedt Company, LLC, and advises healthcare executives on strategy, operations, and effective decision-making. Dr. Kongstvedt is also a Senior Health Policy Faculty member in the Department of Health Administration and Policy at George Mason University. In March 2014, he was appointed by Virginia Governor Terry McAuliffe to serve on Virginia's Board of Medical Assistance Services (Virginia Medicaid), was elected Vice Chair, and in April of 2018 was reappointed by Governor Northam to his second of two terms.

Dr. Kongstvedt's unique business expertise comes from the varied roles he has performed over his long career. Prior to his most recent positions as partner and senior executive in global consulting firms, Dr. Kongstvedt held the most senior-level executive positions at a number of health plans and insurers. His roots as a practicing physician also give him firsthand understanding of the totality of the healthcare profession.

Renowned as the primary author and editor of one of the most widely used books on health insurance and managed care, Dr. Kongstvedt's books are used by more than 256 graduate and undergraduate health administration and policy programs. These books include *The Essentials of Managed Health Care, Sixth Edition* (Jones & Bartlett Learning, 2013), *Health Insurance and Managed Care: What They Are and How They Work, Fourth Edition* (Jones & Bartlett Learning, 2015), and this new *Fifth Edition*.

As a healthcare industry thought leader, Dr. Kongstvedt has been quoted in dozens of trade publications and frequently presents at industry conferences and corporate events. He has consulted and made several appearances on *The CBS Evening News*, and has appeared on NBC's *Today Show*, CNN, and National Public Radio's *All Things Considered*. He has also been quoted in the Wall Street Journal, the Washington Post, and the Los Angeles Times, as well as in numerous trade publications.

A licensed physician, a board-certified internist, and a Fellow in the American College of Physicians, Dr. Kongstvedt received his BS and MD degrees at the University of Wisconsin, where he also completed his internal medicine training and residency. He resides in McLean, Virginia. Further information may be found on his website: www.kongstvedt.com.

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Keeping Current

Keeping current on trends and data presents a significant challenge, including trends and data presented in a book. Fortunately, there are several useful resources accessible via the web that periodically provide updated data and trend information, and discussion of important health policy issues relevant to health insurance and managed health care. Some examples of such sources are provided here, but it is not an exhaustive list. The sources listed also do not represent the only useful types of resources. On the other hand, there are many apparent sources that are less than reliable or outright misleading, but it is up to the reader to sort those out.

Web addresses were current at the time of publication but like the healthcare industry, are always subject to change.

Examples of Federal Sources of Information	
HealthCare.gov, the federal exchange portal	https://www.healthcare.gov
Centers for Medicare & Medicaid Services (CMS), providing further access to a wealth of additional information	http://www.cms.gov
CMS's Center for Consumer Information and Insurance Oversight (CCIIO)	http://www.cms.gov/cciio/index.html
CMS's Innovation Center	https://innovation.cms.gov/
Department of Labor's (DOL) section on Health Plans and Benefits	https://www.dol.gov/general/topic/health-plans
Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov
AHRQ's Healthcare Cost and Utilization Project (HCUP)	https://www.ahrq.gov/data/hcup/index.html
Medicare Payment Advisory Commission (MedPAC)	http://www.medpac.gov
Medicaid and CHIP Payment and Access Commission (MACPAC)	http://www.macpac.gov

Examples of Policy and Research Organizations That Provide Unbiased Data and Information	
The Henry J. Kaiser Family Foundation	http://www.kff.org
Health Systems Research and Educational Trust	http://www.hret.org/
The Commonwealth Fund	http://www.commonwealthfund.org
The Robert Wood Johnson Foundation	http://www.rwjf.org
The Urban Institute, Health and Health Policy	https://www.urban.org/research-area/health-and-health-policy
The National Health Policy Forum	http://www.nhpf.org/home
The Health Care Cost Institute	http://www.healthcostinstitute.org/

Examples of Publications (may require subscription)*	
Health Affairs	http://www.healthaffairs.org
The Milbank Quarterly	https://www.milbank.org/
Health Systems Research	http://www.hsr.org/
Sanofi-Aventis's Yearly Managed Care Digest Series (free after registration)	http://www.managedcaredigest.com
Managed Care Online	http://www.mcol.com

* Most peer-reviewed medical journals are also good sources of data and information but are not included here.

Attribution Note

Portions of the material in this text are adapted in part from their more detailed counterparts in *The Essentials of Managed Health Care, Sixth Edition* (Jones & Bartlett Learning, 2013). Interested readers wanting additional information about health insurance and managed care are advised to consult this reference. In addition, certain portions and exhibits were created and copyrighted by the P. R. Kongstvedt Company, LLC. All such material is used with permission, but not always identified or further attributed.

Prologue: Moral Hazard

Introduction

Is health insurance insurance? The easy answer is mostly no. For one thing, the majority of individuals covered under commercial health benefits plans are in employer self-funded group health plans in which the employer is at risk, not in fully insured plans in which the insurer is at risk for medical costs. But that is a technical distinction, and while it is important for several reasons that are addressed in the book, it is not the reason to ask the question. The reason to ask it is to illuminate the underlying dynamics in health insurance to better make sense of it. Because on its surface it looks like chaos (which, in a technical sense, it is), but it is also a very rational system, at least to one party, although not always rational in a good way to another.

For half a century, the cost of health insurance has stubbornly increased faster than the general rate of inflation. There are myriad reasons why this occurs, many of which are addressed in the book as well as extensively in published articles. But there are also attributes intrinsic to health insurance itself that contribute to cost inflation. But it is not profits. The profit margins for health insurers are a bit below those of hospitals, and well below other industries in the health sector such as pharmaceuticals, biopharmaceuticals, and medical devices. This has been the case for decades and was cemented in place by the Patient Protection and Affordable Care Act (ACA) that singled out the health insurance industry to control profits indirectly through minimum medical loss ratio requirements, allowing only a narrow margin for administration, marketing, and profits.

Being treated as insurance however, comes with some intrinsic attributes. All insurers face these attributes all the time, regardless of type of insurance such as property/casualty, life, annuity, and health insurance. All insurers have developed methods to reduce their impact on cost increases, although health insurers have been more limited than other types of insurers and are markedly limited under the ACA.

Going under the semantically misleading terms "moral hazard" and "inherent vice," these interrelated principles are not difficult to understand in isolation, though regrettably they are often approached that way. But they do not exist in isolation; each exists as a set of related but differing expressions. Moral hazard and inherent vice are not totally ignored in the ACA, but there is considerable variation in what and how effectively they are addressed.

In his landmark 1963 paper, economist and Nobel laureate Kenneth Arrow addressed moral hazard and its application to health insurance, including the pooling of unequal risks, asymmetric knowledge, and issues of trust and delegation.[1] Writing before the passage of Medicare and Medicaid, Arrow argued that the lack of a truly competitive free market for health insurance (i.e., there is no market for those who need it the most: the very sick, older adults, and the poor) means society must fill the void. Two years later, economist Mark Pauly argued that the existence of health

insurance must lead to an increase in demand as the direct cost to an individual of an episode of care goes down, and that some things are simply not insurable.[2]

Since then, moral hazard has traditionally been the domain of economists, and they have written extensively on the topic, including further excellent detailed discussions specifically about health insurance.[3] But it is important for non-economists to understand the concepts as well, particularly for those involved in health policy. The goal of this preface therefore is to illustrate the core concepts of moral hazard and inherent vice as applied to health insurance now and under the ACA, and to do so using plain English, without the use of such terms as price elasticity, welfare losses, marginal utility, or redistributive policy. And to do all this without using math.

Moral Hazard

Moral hazard is not a synonym for Las Vegas or the wages of sin, though it has sometimes been characterized that way in the popular press.[4] But moral hazard has little or nothing to do with morals as we commonly use the term.

Origins of the Term Moral Hazard

It is uncertain when the term moral hazard first came into use or its exact origins. Several researchers found publications from the 19th century associating it with good and bad behavior, such as a person who deliberately burns down an insured building.[5] Others also placed it in the 19th century, but only through recognition that having insurance can itself create a motive to behave differently.[6] Still others, including this author, believe it may have appeared earlier, perhaps as early as the 18th century.

Despite some authors associating it with bad behavior, most agree that in this case, the word moral refers to a state of mind.[7] This is similar to one aspect of its current definition in the *Oxford English Dictionary* as "…psychological rather than physical or practical: *moral support*."[8]

The word hazard may have referred to the familiar definition as "…a danger or risk," but it is at least as likely to have referred to a popular form of gambling, a dice game called "hazard" that is a forerunner of today's craps.[9] This is further supported by the origin of the word hazard from the "…old French *hasard*, from Persian or Turkish, 'dice.'"[10] Or perhaps it came about when some clever 18th or early 19th century underwriter used it as a pun, incorporating both meanings of the word. In any event, it is an apt analogy that moral hazard is like when the dice are rolled, what comes up is not just a matter of chance and statistics, but also the state of mind of the dice thrower.

In simplest terms, moral hazard means a behavior change associated with being partially or wholly insulated from the full economic consequences of an action. In insurance, which is all we will deal with here, it means that the presence of insurance changes the behavior of the insured—or potentially insured—party in a way that increases an insurer's risk because the insured party does not directly bear the full financial cost of actions, inactions, or decisions. As we shall see, it can also affect the behavior of other interested parties too.

Beyond this general concept, the expression of moral hazard is seen in four interrelated ways in all or most types of insurance. While all are expressions of a single principal, it is highly instructive to examine each of the four separately, since addressing one expression does not equate to addressing them all, and all exert an impact at all times, at least on

a population-wide basis. These four expressions are:

1. The Pooling of Unequal Risks
2. Asymmetric Knowledge
3. Induced Demand (which can have two expressions)
4. The Agent–Principal Problem

Inherent vice is a related concept, but because it refers to physical properties it is discussed separately.

The Pooling of Unequal Risks

In an ideal insurance market, all who are insured in a single risk pool have an equal risk of incurring losses. While a perfect market does not exist for any type of insurance, insurers typically identify substantial risk differences and place customers into risk-similar pools; for example, individuals with poor driving records are in a higher risk pool and pay more for their auto insurance than do drivers with good driving records, or a medical malpractice carrier will place all neurosurgeons in a state into a different risk pool than it will place family physicians because neurosurgeons are sued more often and for more money, rightly or wrongly. In this way, the cost of insurance is related to the level of risk. If significantly unequal risks are pooled, premium costs go up for lower-risk individuals or groups, and they are more likely to exit the risk pool altogether.

Insurers also avoid pooling unequal risks by simply refusing to insure high-risk individuals or organizations. For example, a life insurance company typically will not insure the life of somebody with widespread cancer, or a property/casualty insurer will not insure a coastal home built on a sandbar jutting out into the Atlantic.

In health insurance, unequal risk may be separated through age-banding (younger people are in a different risk pool than older people) or categories based on the level of chronic illness (e.g., a very costly high-risk pool for individuals with high health needs). Experience rating is another way of separating unequal risks, in which large- or mid-sized employer groups with high costs also have higher premiums reflecting their own risk. Medical underwriting was another way health insurers avoided pooling unequal risk—by simply not insuring high-risk individuals or groups.

Beginning as of 2014, the ACA required complete pooling of unequal risks in the individual market and, separate from the individual market, the small group market. This was done in several ways. One way was by requiring the use of community rating. Community rating means that for the same products, insurers must charge the same premium rates to individuals or to small employer groups. Many states had required community rating for small groups for many years, so that was not much of a change.

The ACA also limited age-banding to a threefold difference, not the eight or tenfold differences found before the ACA was passed. This necessarily increased the premium cost to younger and healthier individuals. The ACA recognized this in a limited way by allowing for a less expensive high-deductible catastrophic plan with preventive benefits and a small number of office visits, but only for individuals under the age of 30. Insurers are also allowed to charge a higher premium to smokers, which does help offset unequal risks though the intent may have been to discourage smoking.

The real impact of the ACA on the pooling of unequal risk is guaranteed issue, meaning that at least during an annual open enrollment period, an insurer that sells policies to individuals and/or small groups must sell coverage to any individual or group that

wants it, meaning the least insurable individuals or groups could obtain coverage, and for individuals and small groups at least, pay the same price as others in the same risk pool (and for individuals, in the same age band). Guaranteed issue means higher premium costs because the risk pool is sicker, which in turn affects purchasing behavior, which is a topic included in the next section.

Asymmetric Knowledge

Asymmetric knowledge means that one party knows something that the other party does not know, and that can affect risk and costs. The first place this occurs is the decision to purchase insurance. Because the decision to purchase occurs before coverage is in effect, this type of moral hazard is sometimes referred to as "ex ante," meaning before the event. The other three expressions of moral hazard are referred to as "ex post," meaning after the event.

To illustrate this, imagine an 18th century shipping company learns of an increased density of Jolly Rogers in the Caribbean. The shipping company buys insurance, but the insurer is unaware of the increased pirate activity and the shipper does not tell them. The shipper pays a relatively low premium and tells captains to sail right along the faster routes, secure that losses will be covered by the insurer, but the profits from a successful and swift voyage will go to the shipper. This concept is equally applicable to chronically heightened risk such as driving a truck load of unstable nitroglycerin across rough terrain, or to a single event such as wrecking your car the day before, or a recent diagnosis of cancer.

Non-health insurers address asymmetric knowledge in several ways. Underwriters require prospective customers to submit all relevant information to allow them to determine risk or even decline coverage. Policies are written to negate coverage if the insured failed to disclose relevant information. An insurer may also directly obtain it; for example, by inspecting ship's logs, obtaining medical records and even requiring an applicant to undergo a physical examination as part of a life insurance evaluation, or checking with a national database of motor vehicle accidents and violations. Coverage is almost never provided for anything occurring prior to applying for it; for example, no auto insurer is required to sell you a policy today that will cover yesterday's car wreck.

Health insurers once addressed asymmetric knowledge through medical underwriting, but, as already discussed, the ACA prohibited medical underwriting other than claims review for experience rating of large insured groups. In addition to requiring guaranteed issue, the ACA also prohibits rescissions, meaning retroactively stopping coverage, for anything other than fraud or non-payment of premiums. In other words, health insurers are far less able to reduce the impact of asymmetric knowledge compared to all other types of insurers.

Another impact of asymmetric knowledge on purchasing behavior is also related to guaranteed issue, particularly once the individual mandate was not enforced in 2018 and eliminated as of 2019. Healthier individuals can (to return to an earlier metaphor) choose to roll the dice and take a chance on not needing care but obtain coverage if that changes. They cannot obtain coverage other than 1 month per year, which does offset this a bit. In this way, the risk pool contains a higher than average number of sick people who need regular coverage, but not enough healthy people who do not even join the risk pool until they too are sick. The sicker than average risk pool becomes costlier, driving healthier people out but retaining sick people, which results in even higher costs for those who remain. At some point, it can become unsustainable, a dynamic that insurers refer to as a death spiral.

Purchasing behavior needn't be confined to an up-front decision by someone who is currently uninsured. The ACA will allow individuals (or employers) to opt in and back out of the insurance pool with no penalty beyond possible fines for some employer groups.

In 2009 prior to passage of the ACA, Professor Paul Starr of Princeton University had suggested an alternative to an individual mandate, allowing individual adults to opt out of health insurance without facing a fine, but doing so would subject them to exclusions on preexisting conditions for 5 years.[11] Whether this would have mitigated the risk of this form of moral hazard more effectively than the relatively modest fines defined in the ACA is unknown. But with the elimination of the individual mandate, as of 2019 this or a similar concept may yet come into play.

Induced Demand

Induced demand means that having insurance encourages its use. The amount of induced demand varies widely, and most types of insurance have natural limits on induced demand. For example, moral hazard may lead a shipping company to be more willing to sail vessels through risky waters if they are insured, but not to the point of losing half their fleet. And absent felony fraud, the existence of homeowner's insurance does not induce people to burn their houses down. In addition, for most other forms of insurance induced demand is typically confined to a single or a few events.

Health insurance is exactly the opposite. Having health insurance may not induce you to break your leg, but it does result in increasing the amount of healthcare services received, and the less one pays out of pocket the more healthcare services are used.[12] This is not necessarily a bad thing since the uninsured often do not get the care they need and suffer poorer outcomes. Also, at some point, increasing usage drives up costs while providing diminishing returns. But the heart of this aspect of induced demand is this: you are supposed to use health insurance to pay for covered medical services on an ongoing basis, not just when you break your leg.

There are two distinct pathways for induced demand: demand induced by consumers and demand induced by providers. Consumer-induced demand is described here. Provider-induced demand, which is more important, is discussed in combination with the next form of moral hazard, called the agent–principal problem.

While there is no question that the existence of health insurance leads to an increase in consumers' demand for healthcare services, it is unclear how important that is. For example, consumer-induced demand is the precise reason for direct-to-consumer (DTC) advertising by pharmaceutical manufacturers. While there is evidence that DTC increases consumer demand,[13–15] it may be offset by physicians' advice.[16,17] Furthermore, as has been argued in the popular press,[18] except for a small number of troubled individuals, nobody really wants to go to the doctor to have a colonoscopy or get stuck with a needle. On the other hand, in today's medicalized society it is not uncommon for a patient to begin an office visit with a request for a diagnostic procedure. In the end, it is difficult to really gauge the impact of consumer-induced demand since a desire to avoid an unpleasant medical intervention must compete with a desire to be healthy.

One way insurers such as property/casualty insurers address induced demand is through cost-sharing. Losses that are less than the deductible do not result in a claim, and a loss that is only slightly higher than the deductible is unlikely to generate a claim either. For example, if there was no deductible on an auto policy, car owners would have every scratch and ding removed.

Health insurers do the same via copayments, coinsurance, and deductibles. This reaches its peak in high-deductible health plans, including consumer-directed health plans (CDHPs) with associated pretax funds, as described in Chapter 2. The new standardized benefits plans required under the ACA and also described in Chapter 2 allow for the same significant level of cost-sharing as a typical CDHP, so little changes there.

Health insurers can also use a reduction in cost-sharing to deliberately induce demand, as the ACA does by removing cost-sharing for wellness and preventive care, with the deliberate goal of increasing consumer use of prevention. Similar approaches to selectively increasing consumer demand have been used by health insurers' disease management programs as well, using value-based insurance benefits designed to lower economic barriers for certain drugs and interventions in order to increase compliance in chronically ill individuals.[19]

The Agent–Principal Problem

This fourth major expression of moral hazard occurs when the financial interests of a principal's agent are not aligned with those of the principal, and, as a result, the agent's behavior may increase the principal's costs. Non-health insurers address this by requiring certain functions to be done by their own employees or an agent with aligned incentives. For example, a disability insurer might pay a private detective 10% of a recovered fraudulent payout, or an auto insurer will employ a damage assessor to determine exactly what repairs will be covered rather than having the body shop make that determination.

In health care, we typically think of physicians acting as their patients' agent, looking out for their patients' best interest. And that is certainly true, using the broad concept of an agent. But in insurance, and in moral hazard in particular, the physician is the *health insurer's* agent because the physician (or any provider, really) makes decisions that use the insurer's money. This is the result of the third-party payment system in which there is no alignment between the insurer's (the principal's) financial interests and those of the physician (the agent) or the insured. It is made far worse by the fee-for-service (FFS) system that rewards providers for spending the insurer's money by doing and charging more, at little perceived cost to themselves or their patients.

The impact can be exacerbated by provider-induced demand, which differs from consumer induced demand described earlier. Not only does FFS reward providers for doing more, it can reward them for inducing demand that might not otherwise have existed. As discussed extensively in Chapters 4 and 5, for example, physician ownership (or a similar financial relationship) of costly devices such as cardiac imaging is associated with significantly higher levels of utilization when compared to physicians with no financial interest.

In health care, payment alternatives to FFS such as capitation were designed to align the incentives of the agent (the provider) and the principal (the Health Maintenance Organization or HMO), but as HMOs declined in popularity, so did capitation, though it is far from gone. Prospective payment methods such as diagnosis-related groups were also designed to better align incentives, but as discussed in Chapter 5, charge-based outlier payment diminished its impact. Recent approaches such as shared savings and value-based payment are other examples of attempts to realign incentives between the agent and the principal.

Health insurers, and HMOs in particular, also address the agent–principal problem through utilization management for the costlier types of clinical services. The use of evidence-based clinical guidelines for precertification of coverage for elective procedures or high-cost drugs is an example. And on a broader basis, most large insurers use their claims database to look for patterns of regular overutilization, irregular billing, or other expressions of the agent–principal problem, but usually only when something has alerted them to the possibility.

The ACA essentially ignores the agent–principal problem, except for a few provisions applicable to Medicare and Medicaid. It calls for the collection of hospital charge data, although it is not clear how that would differ from chargemaster data currently collected by Medicare and most states, and the relationship between cost and charges in the chargemaster is loose, at best.[20] More encouraging had been the creation of an Independent Payment Advisory Board to provide recommendations to Congress on pricing, but this board was eliminated by Congress in 2018.

Inherent Vice

Inherent vice is more than the title of Thomas Pynchon's fine 2009 novel[21] or of the 2014 film adaption by Paul Thomas Anderson. Inherent vice is an insurance term used most often, but not exclusively, in marine insurance. It refers to an inherent physical property that may cause deterioration or damage, for example, a cargo container full of rotting fruit, a truck carrying 10 barrels of unstable nitroglycerine, or 3 tons of metallic sodium sitting open in the hold of a leaky ship. Even if discovered after the policy has been issued, a marine insurer will not pay for losses incurred as a result of undisclosed or undetected inherent vice. Inherent vice is simply the other side of the moral hazard coin—where moral hazard refers to a willful behavior, inherent vice refers to a physical state though in health insurance, both are usually involved in the case of asymmetric knowledge.

If it were confined to that, it would not be worth discussing. But inherent vice is a broader concept because life itself is ultimately a fatal condition. As we age, we accumulate more clinical events and conditions, even if we were perfectly healthy when we were first insured. At some point that risk passes from a commercial insurer to Medicare, but the underlying dynamics do not change.

The risk from inherent vice also increases through real vice; for example, smoking, alcohol and drug abuse, reckless driving, and so forth. Behaviors such as obesity, which may or may not be considered a vice, also has an impact. To its credit, the added risk caused by unhealthy behavior is recognized in the ACA, and a strong emphasis has been put on wellness and prevention, including in the benefits designs and funding for prevention programs. The ACA even addresses it by allowing for significant incentives for participation in preventive services. These incentives may take the form of premium contribution, in effect allowing for differences of up to 30% (or even 50% if allowed by the Secretary). Furthermore, premium rate adjustments of up to 1.5 for individuals and small groups will be allowed based on tobacco usage.

These measures could improve health but will not offset the increased risks created by removal of the more traditional approaches of medical underwriting and coverage limitations. In counterpoint, a recent analysis of prevention concluded that "less than 20 percent of the preventive options fall in the cost-saving category—80 percent add more to medical costs than they save."[22] Prevention is important and the right thing to do, but not because it lowers costs.

Insurance Versus Financing

Moral hazard and inherent vice are insurance terms, and broadly speaking, insurance means indemnifying a person or company against unanticipated or unlikely financial losses from a one-time or rare event or cost; for example, a house fire, a sinking ship, or hurricane damage. It can also refer to premature loss or damage when the risks are highly predictable in large populations; for example, life or disability insurance.

Conversely, services that are used repeatedly are often not insured but are financed, even if their use varies by individual. In some cases, this is through taxation; for example, property taxes to pay for public schools or income taxes to pay for state police or the protection provided through the U.S. Uniformed Services. In other cases, it is done through private subscription; for example, monthly payments for telephone service, cable television, or Internet access. Most individuals do not see a doctor as often as they watch television or use online social media each day, but they do see a doctor far more often than they wreck their car, become disabled, or lose a ship to pirates. In this way, health care more closely resembles goods and services that are financed, not insured.

As described in some detail in Chapter 1, the origin of health insurance and managed health care in the United States was also through financing, not through insurance. The earliest forms of coverage were all prepaid plans, including some that were much like modern group model HMOs, or prepaid employee welfare benefits or service plans that were the forerunners of today's Blue Cross and Blue Shield plans. That financing of health services migrated came to be seen as a form of insurance is due at least in part to its inclusion as an employee benefit under the 1942 Stabilization Act that imposed wage and price controls on businesses, and the increased use of insurers that were already selling benefits products to employers took on health coverage too, putting it squarely into the realm of insurance. Over time, the prepaid service plans and HMOs, all of which were nonprofit then, came under the same umbrella. But calling it health insurance did not and does not make it the same as the other types of insurance.

Many nations deal with coverage and payment for healthcare services as financing by using a combination of taxation and fees, though some countries call those fees premiums. In most cases of financed services, the entities collecting the taxes or subscription fees also provide the service directly or strictly control its delivery. For example, the school district owns the building and hires the teachers. The same concept often applies in other nations, where the state owns the hospitals and employs hospital-based specialists, though less often the primary care physicians. In this way, they are less subject to cost and revenue fluctuations because those facilities operate under a budget, distribution of high-cost services is centrally planned, and governments are better positioned to demand favorable pricing on devices and drugs. That does not necessarily make it better than the United States, but it is undeniably less expensive.

Governments that finance health benefits and in which at least some healthcare services are provided by private providers also usually attempt to offset at least some of the impact of moral hazard through price controls on providers, blunting the capacity for price inflation. Medicare does this to some degree in the United States, and an analysis of Maryland's all-payer hospital rate setting system concluded that for the commercial sector it was an "enduring and successful cost containment program,"[23] though some dispute that conclusion. Most governments that finance their systems also blunt the impact of induced demand

through controlling the supply of providers or the capacity of hospitals. This would usually result in price increases, but price controls stop that. However, anything in finite supply may be considered in economic terms; for example, time is in limited supply, so queuing is a form of increased prices, paid directly by consumers as waiting times instead of by third party payers as money.

Other nations are far from immune to increasing healthcare cost pressures, of course. They face the same issues of new technology, aging populations, new procedures, and so forth. As a result, while other nations spend far less per capita than the United States does for healthcare services, they too face inflation rates above their general rates of inflation. The response by other nations is a combination of greater spending and greater queuing, while spending increases are the primary response in the United States.

It would be misleading, though, to simply conclude that the answer to "Is health insurance insurance?" is simply "No." Financing is applied more easily to regular services for most individuals. It is more easily budgeted, and resources may be more fairly allocated. But as discussed in Chapter 5, a small percentage of unfortunate individuals experience medical problems that generate catastrophic levels of cost, and in those cases it is the insurance aspect that protects them from losses. By eliminating annual and lifetime benefit maximums, the ACA reduces the serious medical debt and medical bankruptcies experienced prior to its passage, though this is offset by steady increases in cost-sharing. Prohibiting annual and lifetime benefits limits also increases the insurance aspect of protection in that it indemnifies individuals from catastrophic financial exposure. In any event, as demonstrated during the rancorous debate culminating in passage of the ACA, our society is not ready to embrace approaches used by other industrialized nations to finance their healthcare systems. That being the case, the insurance aspects of health benefits coverage will continue to exert significant influence, including moral hazard.

Conclusion

So the answer to "Is health insurance insurance?" is "Sometimes it can be, but most of the time it is not." As necessary as reform is, focusing only on health insurance *as insurance* has the unintended effect of increasing the impact of moral hazard, potentially accelerating cost inflation in the commercial sector. Having a healthier population and reducing human suffering is important, humane, and was long overdue (assuming the ACA remains the law of the land, at least in part). But the cost of doing so increases under some provisions of the ACA due to perfectly rational economic behaviors of patients and providers that are usually not immoral. It has driven behavior for a long time and will continue to drive it as discussed in this Preface. Understanding that will help you to understand why our system often behaves the way it does. Finally, reforming health insurance as insurance also means that we have not reformed the health system in the United States. That is yet to come.

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CHAPTER 1

A History of Managed Health Care and Health Insurance in the United States*

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LEARNING OBJECTIVES

- Understand how health insurance and managed care came into being.
- Understand the forces that have shaped health insurance and managed care in the past.
- Understand the major obstacles to managed care historically.
- Understand the major forces shaping health insurance and managed care today.

Introduction

Health insurance and managed health care are inventions of the 20th century. For a long time, they were not considered to be "insurance" but rather "prepaid health care" (i.e., a way of accessing and paying for healthcare services rather than protecting against financial losses). From its inception, this set of arrangements has been in a never-ending state of foment. This chapter explores the historical roots and evolutionary forces that have resulted in today's system. The dates mentioned in this chapter are specific for such events as the passage of laws and the establishment of some organizations but only approximate for trends.

* This chapter is adapted from Fox PD, Kongstvedt PR. A history of managed health care and health insurance in the United States. In: Kongstvedt PR, ed. *The Essentials of Managed Health Care*. 6th ed. Burlington, MA: Jones & Bartlett Learning; 2013.

The 19th Century

Before the 20th century, health insurance as we think of it today did not exist. For a long time, there existed forms of insurance such as burial insurance, and there were some protections in law for costs rising from work-related injuries.

Beginning in the 19th century, there appeared some forms of health-related benefits. For example, a few of the larger trade unions provided limited financial protections related to illness in order to help protect members' jobs. Many of the railroad companies serving the West, such as the Southern Pacific, the Missouri Pacific, and the Northern Pacific, developed "hospital associations" and employed physicians to make sure that care would be available to treat sick or injured employees working in areas where there was little care.[1] This model would be seen again—but with more lasting consequences—when the Kaiser Construction Company sponsored what would become the Kaiser Health Plan, as described in a later section.

At least two lonely and fleeting examples of true commercial health insurance companies came into existence in 1847. That year, the aptly named Health Insurance Company of Philadelphia[2] offered the first individual commercial health insurance in the United States. Also, the Massachusetts Health Insurance of Boston[3] offered the first group commercial health insurance. Both failed due to their attracting sick populations and not setting prices high enough to cover costs. One author reports that, by 1866, 60 organizations offered accident insurance, but not health insurance as we think of it today.[4]

1910 to the Mid-1940s: The Early Years

The years before World War II saw the development of two models of providing and paying for health care besides the patient simply paying for the service. The first was early forms of what is now called a health maintenance organization (HMO), though this term was not actually coined until the early 1970s. Such a model relies on an organization that is capitated (i.e., that charges a preset amount per member, or per enrollee, per month) and that provides services directly through its facilities and personnel, thereby combining the functions of financing and delivery. The second was the early Blue Cross and Blue Shield plans, which paid for services provided by contracted community doctors and hospitals, which also regularly served patients not covered by these plans.

Prepaid Medical Group Practices

The Western Clinic in Tacoma, WA is often cited as the first example of prepaid medical group practice. Started in 1910, the Western Clinic offered, exclusively through its own providers, a broad range of medical services in return for a premium (capitation) payment of $0.50 per member per month.[5] The program, which was offered to lumber mill owners and employees, served to assure the clinic a flow of patients and revenues.

A notable year in the history of health plans was 1929. In that year, Michael Shadid, MD, established a rural farmers' cooperative health plan in Elk City, OK by forming a lay organization of leading farmers in the community. Participating farmers purchased shares for $50 each to raise capital for a new hospital in return for receiving medical care at a discount.[6] For his troubles, Dr. Shadid lost his membership in the county medical society and was threatened with suspension of his license to practice. Some 20 years later, however, he was vindicated by a favorable out-of-court settlement resulting from an antitrust suit against the county and state medical societies.

Also in 1929, Doctors Donald Ross and H. Clifford Loos established a comprehensive prepaid medical plan for workers at the Los Angeles Department of Water and Power. It covered physician and hospital services. From

the outset, it focused on prevention and health maintenance.[7] For that reason, some consider it to be the first real HMO. Doctors Ross and Loos were also expelled from their local medical society.

Despite opposition from the American Medical Association (AMA), prepaid group practice formation continued for many reasons, including employers' need to attract and retain employees, providers' efforts to secure steady incomes, consumers' quest for improved and affordable health care, and even efforts by the housing lending agency to reduce the number of foreclosures caused by health-related personal bankruptcies. Two prominent examples from this time period are the Kaiser Permanente Health Plans in California and the Group Health Association (GHA) of Washington, D.C., which subsequently became part of the Kaiser system. They, too, were opposed by local medical societies.

The organization that evolved into the Kaiser Permanente Health Plan was started in 1937 by Dr. Sidney Garfield at the behest of the Kaiser Construction Company. It sought to finance medical care, initially for workers and families who were building an aqueduct in the southern California desert to transport water from the Colorado River to Los Angeles and, subsequently, for workers who were constructing the Grand Coulee Dam in Washington State. A similar program was established in 1942 at Kaiser ship-building plants in the San Francisco Bay area.

In 1937 the GHA was started in Washington, D.C., at the behest of the Home Owners' Loan Corporation, to reduce the number of mortgage defaults that resulted from large medical expenses. It was created as a nonprofit consumer cooperative with a board that was elected by the enrollees. The District of Columbia Medical Society vehemently opposed the formation of GHA. It sought to restrict hospital admitting privileges for GHA physicians and threatened expulsion from the medical society. A bitter antitrust battle ensued, culminating in the U.S. Supreme Court's ruling in favor of GHA. In 1994, faced with insolvency despite an enrollment of some 128,000, GHA was acquired by Humana Health Plans, a for-profit, publicly traded corporation. It was subsequently divested by Humana and incorporated into the Kaiser Permanente Health Plan of the Mid-Atlantic.

The Blues

Blue Cross (BC) began in 1929 when Baylor Hospital in Texas agreed to provide some 1500 teachers with prepaid inpatient care at its hospital. The program was later expanded to include participation by other employers and hospitals. State hospital associations elsewhere created similar plans. Each was independent of the others, as they are today. In 1939 the American Hospital Association (AHA) adopted the BC emblem and created common standards. The symbol was subsequently transferred to the Blue Cross Association (BCA) in the early 1960s, and the AHA ended its involvement with the BCA a decade after that.

The first type of organization that would become the basis for Blue Shield (BS) plans elsewhere (though it was not itself a BS plan) originated in the Pacific Northwest in 1939, when lumber and mining companies sought to provide medical care for their injured workers. Those companies entered into agreements with physicians, who were paid a monthly fee through a service bureau—a type of organization that would evolve into the service plans found at the core of most BC and BS plans today (see Chapter 2).[8]

The appearance of the first actual BS plan is difficult to establish due to differences among information sources. One source states that the BS logo first appeared in Buffalo, NY, as early as 1930.[9] Most sources state that the first official BS plan was the California Physicians' Service plan created by the California Medical Association in 1939.[10,11] In any event, other state medical societies soon emulated this model. Like the BC plans, the new BS plans were independent of both each other and

the BC plans in their respective states but were nevertheless associated with them.

The earliest BC and BS plans were prepaid health benefits plans, not insurance. Unlike the earlier prepaid group practices and cooperatives, BC and BS plans relied on independent providers rather than employing physicians or contracting with a dedicated medical group.

To define the payment terms between a BC plan and a hospital, hospitals created cost-based charge lists, the forerunners of today's hospital chargemaster, and BS plans developed payment rates for defined procedures based on profiles, the forerunners of what became Usual, Customary and Reasonable (UCR). Provider payment, including the chargemaster and UCR, is discussed in Chapter 4. Initially, BC plans provided coverage only for hospital-associated care (including some skilled nursing home care), while BS plans provided coverage for physician and related professional services (such as physical and speech therapy). Over time, many BC plans merged with their local BS counterparts to become joint BCBS plans, although some remain separate even now. Many of these BC and BS plans were statewide and did not compete with each other, albeit with some exceptions; for example, Pennsylvania has several BC and/or BS plans.

From the beginning, the BC and BS plans, collectively referred to as the "Blues," operated independently from each other. In the past several decades, however, a significant number of BC and BS plans have merged to form multistate entities. Although Blue plans are independent companies that license the BC and/or BS logo(s), they do not usually compete with each other directly as Blue plans, with a few exceptions; for example, Anthem Blue Cross of California and Blue Shield of California compete directly, and Regence Blue Shield of Idaho competes with the Blue Cross plan in that state.

Hospitals and physicians retained control of the various Blues plans until the 1970s. In that decade, these plans changed to either a community governance model with a self-perpetuating nonprofit board not controlled by the providers or to a structure under which the board was elected by the insureds (i.e., a mutual insurer). In recent decades, many Blues have converted to publicly owned for-profit corporations.

Importantly, the formation of the various BC and BS plans in the midst of the Great Depression, as well as the emergence of many prepaid group practices, was not driven by consumers' demands for coverage or entrepreneurs' seeking to establish a business but rather by providers' desire to protect their incomes.

The Mid-1940s to the Mid-1960s: The Expansion of Health Benefits

In the United States, World War II generated both inflation and a tight labor supply, leading to the 1942 Stabilization Act.[12] That act imposed wage and price controls on businesses, including limiting their ability to pay higher wages to attract scarce workers. However, the Act did allow workers to avoid taxation on employer contributions to certain employee benefits, including health benefits. Also, health benefits were not constrained by wage controls. The twin effects of favorable tax treatment and the exemption from wage controls fueled the growth of commercial health insurance as well as greater enrollment in the Blues. Before World War II, only 10% of employed individuals had health benefits from any source, but by 1955 nearly 70% did, although many of these plans covered only inpatient care.

HMO formation and enrollment growth also continued, albeit at a slower pace. Newly formed plans included (1) the Health Insurance Plan (HIP) of Greater New York, created

in 1944 at the behest of New York City, which wanted coverage for its employees,* and (2) Group Health Cooperative of Puget Sound (GHC), organized by 400 Seattle families, each of whom contributed $100. GHC remains a consumer cooperative to this day.

The McCarran-Ferguson Act,[13] passed in 1945, prohibited the federal regulation of insurance companies. As a result, regulation of health insurance devolved to the states. The McCarran-Ferguson Act also provided limited antitrust immunity for certain activities such as pooling of claims data for underwriting purposes (i.e., deciding whom to cover and the premiums to charge). In the absence of federal authority, the regulation of insurance companies and premium levels became the responsibility of the states, which varied widely in their level of oversight, as indeed they do now.

In the 1950s, as a competitive reaction to group practice-based HMOs, a different structure of HMO evolved known as the independent practice association (IPA). In an IPA an HMO contracts either directly with physicians in independent practice or indirectly with an organization that, in turn, contracts with these physicians. In contrast, early HMOs had their own dedicated medical staffs. The basic IPA structure was created in 1954 to compete with Kaiser when the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation. The Foundation paid physicians using a relative value fee schedule, which it established; heard consumer grievances against physicians; and monitored quality of care. This organization became licensed by the state to accept enrollee premiums and, like other HMOs, performed the insurance function, but under a different regulatory structure than standard insurance. In most states, HMOs—then and now—have faced different regulatory requirements than insurance companies.

The Mid-1960s to the Mid-1970s: The Onset of Healthcare Cost Inflation

In the early 1960s, President John F. Kennedy proposed what eventually became Part A of Medicare. This program, which, similar to Social Security, was financed through taxes on earned income (i.e., not investment income), was intended to cover mostly hospital services. The Republicans in Congress then proposed to cover physician and related professional services as well in what became Part B of Medicare. This program was to be financed through a combination of general revenues and enrollee premiums. Following Kennedy's assassination, President Lyndon B. Johnson worked aggressively to achieve some of the late president's domestic goals, including covering individuals age 65 and older.

In 1965 Congress established two landmark entitlement programs: Medicare for the elderly (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act) for selected low-income populations. In 1972 the Medicare Act was amended to cover selected disabled workers (but not their dependents), mostly those who had permanent disabilities starting 29 months after the onset of the disability. It also created near-universal entitlement for patients with kidney disease, in effect creating a single payer system for patients with that particular condition.

The benefits and provider payment structures of Medicare of the time were like those of BC and BS plans, with separate benefits for hospitalization paid through Medicare Part A and physician services paid through Medicare Part B, something that continues to this day in the traditional Medicare program (see Chapter 7).

* HIP subsequently merged with New York-based Group Health Incorporated (GHI) to form EmblemHealth.

The combination of private insurance, Medicare, Medicaid, and other governmental programs such as those of the Department of Defense and the Veterans Administration resulted in the majority of health care being paid for by third-party payers. The third-party payment system severs the financial link between the provider of the service and the patient—a disconnect that fosters increases in both the price of services and their utilization.

These developments marked the beginning of a long history of healthcare cost inflation attributable to the combination of the third-party payment system, advances in medical science, and increased demand by consumers. To illustrate, in 1960, 55.9% of all healthcare costs nationally were paid by the patient, but that percentage declined steadily, leveling out at 11%–12% by 2012 and continuing through at least 2016.[14] At the same time, national health expenditures as a percentage of the gross domestic product (GDP) rose from 5.8% in 1965, the year before Medicare was implemented to 7.4% in 1970 and 17.9% in 2016.[15] Importantly, the rise in healthcare costs over time reflects the joint effects of Medicare/Medicaid and private insurance, not just the government programs alone.

As costs rose, isolated examples of early attempts to control costs beyond seeking provider discounts can be cited; for example:

- In 1959 Blue Cross of Western Pennsylvania, the Allegheny County Medical Society Foundation, and the Hospital Council of Western Pennsylvania performed retrospective analyses of hospital claims to identify providers or patients with utilization that was significantly above average.[16]
- Around 1970 California's Medicaid program began hospital precertification and concurrent review in conjunction with medical care foundations in that state, typically county-based associations of physicians who volunteered to participate, the first of which was the Sacramento Foundation for Medical Care.
- The 1972 Social Security Amendments authorized professional standards review organizations (PSROs) to review the appropriateness of care provided to Medicare and Medicaid beneficiaries. PSROs subsequently became known as peer review organizations (PROs) and then as quality review organizations (QIOs). QIOs continue to oversee clinical services on behalf of Medicare and many state Medicaid agencies today.

In the 1970s a handful of large corporations initiated second-opinion requirements as well as precertification and concurrent review for inpatient care (see Chapter 5), to the dismay of the provider community. Some companies took other measures such as promoting employee wellness, sitting on hospital boards with the intent of constraining their costs, and negotiating payment levels directly with providers.[17]

The problem of healthcare costs rising faster than costs in the economy as a whole, thereby consuming an ever-larger share of the GDP, increasingly became a subject of public discussion in the 1970s. Throughout the 1960s and into the early 1970s, HMOs played only a modest role in the financing and delivery of health care, although they were a significant presence in a few communities, such as in the Seattle area and parts of California. In 1970, the total number of HMOs ranged between 30 and 40, with the exact number depending on one's definition. That would soon change.

The Mid-1970s to the Mid-1980s: The Rise of Managed Care

Between 1970 and 1977, national health expenditures as a percentage of GDP rose from 7.4% to 8.6%. The acceleration in healthcare cost increases, driven in large measure by a high

percentage of the medical dollar being paid for by insurance, private and public (notably Medicare and Medicaid), rather than by the patient became widely discussed and led to the next major development: managed health care as we know it today. In particular, this period saw the growth of HMOs, the appearance of a new model, the preferred provider organization, and widespread adoption of utilization management by health insurers.

Health Maintenance Organizations

In 1973 the U.S. Congress passed the HMO Act.[18] This legislation evolved from discussions that Paul Ellwood, MD, had in 1970 with the leadership of the U.S. Department of Health, Education, and Welfare (which later became the Department of Health and Human Services)[19] as the Richard M. Nixon administration sought ways to address the rising costs of the Medicare program.

These discussions resulted in a proposal to allow Medicare beneficiaries the option of enrolling in HMOs, which were to be capitated by the Medicare program—a change that was not actually adopted until 1982. However, the legislative debate resulted in the enactment of the HMO Act of 1973. The desire to foster prepaid HMOs reflected the view that third-party (insurance) payments on a fee-for-service basis gave providers incentives to increase utilization and fees. Ellwood is also widely credited with coining the term "health maintenance organization" at that time as a substitute for "prepaid group practice" because it had greater cachet.

The HMO Act included three important features:

- It made federal grants and loan guarantees available for planning, starting, and/or expanding HMOs.
- The federal legislation preempted state laws that restricted the development of HMOs.
- The "dual choice" provision required employers with 25 or more employees that offered indemnity coverage to also offer at least one group or staff model and one IPA-model federally qualified HMO, but only if the HMOs formally requested to be offered (see Chapter 2).

The dual choice mandate was used by HMOs of the time to get in the door of employer groups to become established. Because the federal mandate applied to only one HMO of each type, opportunities to exercise the mandate were limited, although employers were free to offer as many HMOs as they liked. The dual choice requirement expired in 1995. Nevertheless, even more than the other provisions, the dual choice mandate is widely regarded as providing a major boost to the HMO industry at a time when it was in its infancy.

To be federally qualified, HMOs had to satisfy a series of requirements such as meeting minimum benefit package standards, demonstrating that their provider networks were adequate, having a quality assurance system, meeting standards of financial stability, and having an enrollee grievance process. Many states ultimately adopted these requirements for all state-licensed HMOs.

Unlike a state license to operate, federal qualification as an HMO was voluntary. However, many HMOs became federally qualified to avail themselves of the HMO Act's dual choice features and because such qualification represented a type of "Good Housekeeping Seal of Approval" that employers and consumers trusted. Although federal qualification no longer exists, it was an important step when managed care was in its infancy and HMOs were struggling for inclusion in employment-based health benefits programs. The expiration of federal qualification inspired the creation of health plan accreditation as a replacement "seal of approval."

The HMO Act imposed requirements on HMOs that were not levied on indemnity health insurers. Examples of requirements that

applied to HMOs, but not to standard insurance, included the following:

- A level of comprehensiveness of benefits, including little cost-sharing (see Chapter 2) and the coverage of preventive services, that exceeded what insurers at the time typically offered.
- The holding of an annual open enrollment period during which HMOs had to enroll individuals and groups without regard to health status.
- Prohibiting the use of an individual's health status in setting premiums.

These provisions applied only to federally qualified HMOs, making them potentially uncompetitive compared to traditional health insurance plans. The HMO Act was amended in the late 1970s to lessen this problem.

The HMO Act was largely successful. During the 1970s and 1980s, HMOs grew and began displacing traditional health insurance plans. What was not anticipated when the original HMO Act was passed was the rapid growth in IPA-model HMOs. By the late 1980s, enrollment in IPAs exceeded enrollment in group and staff model HMOs, a difference that has increased over time. This dynamic accelerated as commercial insurers and BCBS plans acquired or created their own HMOs, most of which followed the IPA model.

The original concept of using federally qualified HMOs in the Medicare program finally came into being in 1982 with the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA).[20] The intent, which was largely achieved, was that the ability of HMOs to control healthcare costs would encourage these plans to offer more comprehensive benefits than traditional Medicare. For example, the new Medicare HMOs typically required less cost sharing than did traditional Medicare and offered coverage of prescription drugs and selected preventive care. However, considerable debate arose as to whether HMOs were able to offer the additional benefits within the Medicare capitation amount because they were more efficient or because of favorable selection (i.e., because they attracted a disproportionate share of healthy patients).

Also in 1982, the federal government granted a waiver to the state of Arizona that allowed it to rely solely on capitation, and not offer a fee-for-service alternative, in the state's Medicaid program.[21] A number of states had previously made major efforts, under federal demonstration waivers, to foster managed care in their Medicaid programs but had not done so statewide. That practice is now widespread. (Managed care in Medicare and Medicaid is discussed in Chapter 7.)

HMOs were increasingly accepted by consumers, due not only to their lower premiums and reduced cost sharing but also because of their more extensive benefits, such as coverage of preventive services, children's and women's preventive health visits, and prescription drugs, most of which were not covered by the typical traditional plans of the time. HMOs were not required to offer coverage of prescription drugs but most did so to attract enrollees. In response to the competition from HMOs, many traditional insurance carriers and BCBS plans began to add coverage of prescription drugs and preventive services to their non-HMO products.

Self-Funded Health Benefits Plans

Another change occurred in 1974, one that attracted little initial attention in the health insurance and managed care sector, was the passage of the Employee Retirement Income Security Act (ERISA).[22] ERISA was created primarily to protect employees from underfunded corporate pensions but was written to cover any type of employee welfare benefit plan for which the employer was financially responsible for providing the benefits. Over time, pensions began to decline as a defined benefit, but employee group-health benefits plans grew, as did their cost.

Under ERISA, self-funded benefits plans are exempt from state laws and regulations. The plans entail employers' retaining the risk rather than paying premiums. They either pay claims and perform other aspects of administration themselves, or more commonly contract with an outside vendor, which could be an insurance company.* Employers saved by not contributing any money towards insurer profits, and by not having to pay state premium taxes. They, also, were not regulated by states or required to meet state minimum benefit requirements, such as coverage of mental health or maternity services. Because the employer was at risk, most bought reinsurance to protect them from serious losses (see Chapter 2).

Finally, ERISA also established appeal rights for denial of benefits, requirements for handling benefits claims, and various other new regulations for employers that self-funded their benefits plans, topics that are addressed further in Chapters 2, 6, and 8.

Preferred Provider Organizations

The growth of HMOs led to the development of another type of managed care plan: Preferred Provider Organizations (PPOs). PPOs are generally regarded as having originated in Denver, CO. In that city in the early 1970s, Samuel Jenkins, a vice president of Martin E. Segal Company, a benefits consulting firm, negotiated discounts with hospitals on behalf of its self-insured clients.[23] Hospitals granted discounts in return for enrollees having lower cost sharing if they used the contracting hospitals, thereby attracting patients away from competitor hospitals.

The concept soon expanded to include physicians and other types of providers. The term PPO arose because hospitals and doctors who agreed to discounted fees were considered to be "preferred" by the health insurance plan. People covered under the PPO faced lower cost sharing if they saw a PPO provider rather than a non-contracted, or "out of network," provider.

Unlike most HMO coverage at the time, PPO benefits did not require authorization from the patient's primary care physician (PCP) to access care from specialists or other providers. PPO providers agreed to certain cost-control measures. For example, they agreed to comply with precertification requirements for elective hospitalizations, meaning that, for the service to be covered, the doctor had to obtain approval before ordering any elective hospital admission or selected high-cost outpatient service. Precertification programs remain common today. Second-opinion programs were also instituted, whereby patients were required to obtain a second opinion from a different surgeon for selected elective procedures. Second-opinion programs are rare today.

Utilization Management

Another development in indemnity insurance, which occurred mostly during the 1980s, was the widespread adoption of large case management—that is, the coordination of services for patients with expensive conditions requiring treatment by multiple providers. Examples include patients who had experienced accidents, cancer cases, patients with multiple chronic illnesses causing functional limitations, and very low-birth-weight infants.†

Utilization review, the encouragement of second opinions, and large case management all entailed at times questioning physicians' medical judgments, something that had been

* The same principles also apply to joint union-management plans (known as Multiemployer Plans or as Taft-Hartley Plans., established under the Taft-Hartley Act of 1948), plus churches and some other plans established by various affinity groups.

† The lack of coordination of medical services remains a persistent problem in the healthcare system—one that managed care was supposed to alleviate, which it has done to a limited extent.

rare outside of the HMO setting. These activities were crude by today's standards of medical management but represented a radically new role for insurance. They sometimes met with ferocious opposition in the medical community, with physicians' complaining that the programs constituted "cookbook medicine" or interfered with the "right" of the doctor to make unfettered medical decisions.

Utilization management by HMOs contributed to practice pattern changes, including shifting care from the inpatient setting to the outpatient setting and shortening the length of hospital stays. Shortening length of stay was also fostered by legislation enacted in 1982 under which the Medicare payment system no longer paid a hospital's actual cost (albeit with upper limits on payments that affected particularly expensive hospitals) but instead paid a fixed amount per admission within a given class or grouping of diagnoses—an approach that some private health plans also adopted.

The Mid-1980s to the Late 1990s: Growth and Consolidation

From the mid-1980s through the mid-1990s, managed care grew rapidly while traditional indemnity health insurance declined, creating new strains on the U.S. healthcare system. At the same time, new forms of managed care plans and provider organizations appeared, and the industry matured and consolidated. That growth was not trouble free, however.

Managed Care Expands Rapidly

HMOs grew rapidly, with commercial HMO enrollment increasing from 15.1 million in 1984 to 63 million in 1999.[24] Initially, PPOs lagged behind, but by the early 1990s enrollment was roughly equal: By 1999, PPOs had a 39% market share, compared to HMOs at 28%. This growth came at the expense of traditional indemnity health insurance. In the mid-1980s, traditional indemnity insurance accounted for three-fourths of the commercial market; by the mid-1990s, it represented less than one-third of the market and that share would decline to single digits by 2000.[25]

A new product was also introduced during this period—the point-of-service (POS) plan. In a POS plan, members had HMO-like coverage with little cost sharing if they both used the HMO network and accessed care through their PCP; unlike in a "pure" HMO, however, they still had coverage if they chose to get non-emergency care from out-of-network providers but were subject to higher cost sharing if they did. Members typically had to designate a PCP, who approved any referral to specialists and other providers (e.g., physical therapists) except in emergency situations. Although they were initially popular, POS plans stalled out. One reason was high costs compared to an HMO that were mostly associated with members requesting their in-network PCP authorize coverage for services received from an out-of-network provider, resulting in the coverage for costly services not being offset by higher member cost-sharing. The other reason was that their complexity made it difficult for members and providers to understand, and they were relatively costly to administer.

These and other hybrid products make statistical compilations related to managed care trends difficult. As new types of plans appeared, the taxonomy of health plan types expanded and lines were blurred, with the term managed care organization (MCO) eventually coming to represent HMOs, POS plans, PPOs, and a myriad of hybrid arrangements. Medicare and Medicaid also witnessed significant managed care growth. Medicare enrollment in capitated plans—that is, plans such as HMOs that set premiums and assumed the risk for the delivery of services—grew from 1.3 million to 6.8 million between 1990 and 2000.[26] During that same time period, Medicaid managed care

grew from 2.3 million (10% of Medicaid beneficiaries) to 18.8 million (56%).[27]

As is the case with dandelions, rapid growth is not always good. Some MCOs outstripped their ability to run their businesses, as evidenced by overburdened management and poorly functioning information systems, resulting at times in poor service and mistakes. In their quest to continually drive down utilization, some HMOs became increasingly aggressive. More ominously, the industry began to see health plan failures or near-failures.

Consolidation Begins

Beginning in the early 1990s, the pace of consolidation quickened among both MCOs and health systems. Entrepreneurs, sensing financial opportunities, acquired or started HMOs with the goal of profiting by later selling the HMO to a larger company. In other cases, they acquired smaller plans to build a regional or national company, enhancing their ability to issue stock. However, not all plans could be sold at a profit, and in some cases troubled MCOs made good acquisition targets, allowing larger plans to acquire market share at minimal expense. Although uncommon, MCOs that were getting close to failure might be seized by a state insurance commissioner, who would then either sell the MCO to another company or liquidate it and divide the membership among the remaining MCOs in the state.

As the market consolidated, smaller plans were at a disadvantage. Large employers with employees who were spread out geographically favored national companies at the expense of local health plans. For smaller plans, the financial strain of having to upgrade computer systems continually and adopt various new technologies mounted. In addition, unless they had a high concentration in a small market, smaller plans found themselves unable to negotiate the same discounts as larger competitors. At some point, many simply gave up and sought to be acquired. Not all mergers and acquisitions were large companies acquiring small ones. Some large companies also merged or were acquired. By 1999, multistate firms, including Kaiser Permanente and the combined Blue Cross and Blue Shield plans, accounted for three-fourths of U.S. enrollment in managed care plans.

Another trend saw health plans convert from not-for-profit to for-profit status. For example, the largest publicly traded managed care company in the United States is currently United Health Group, the corporate parent of United Health Care, which started as a nonprofit health plan in Minnesota. Likewise, U.S. Health Care, a Pennsylvania HMO company, converted from nonprofit to for-profit status and was eventually acquired by Aetna.

Many years earlier, the Blue Cross and Blue Shield trademarks became the property of the Blue Cross Blue Shield Association (BCBSA) that represents member plans. The BCBSA created standards that member plans had to meet to use the Blues trademarks, including a prohibition on being for-profit.

Breaking with that tradition, in 1994 the BCBSA voted to allow member plans to convert to for-profit status. The reasons leading to this shift were financial. Since their beginnings, Blues plans had been exempt from paying taxes as "Charitable and Benevolent Health Insurance plans," but the Tax Reform Act of 1986[28] revoked that exemption because Congress determined that Blues plans were selling insurance in an open market.* At the same time, BCBS plans were losing market share and were not able to keep up with changing operational demands because of a lack of capital—something that publicly traded companies were able to obtain through the sale of stock. Converting to for-profit status would

* That Act did, however, allow for some special tax treatments for nonprofit BCBS plans acting as "insurers of last resort."

therefore have little impact on the Blues' tax status, but would allow them to access capital to improve their competitive position.

Blue Cross of California was the first to convert to for-profit status, which they did under the corporate name of WellPoint. The Indiana Blues soon followed under the corporate name Anthem. Other Blues plans also converted and were subsequently acquired by WellPoint or Anthem, and in 2004 Anthem merged with WellPoint. These conversions required the creation and funding of foundations, commonly known as "conversion foundations," which held the assets of the nonprofit plan that were then used for the benefit of the states or regions where the converted plan was located. Many of these entities are among the largest grant-giving foundations in their respective states.

Consolidation also took place among health plans that were not publicly traded, albeit at a slower rate. By the end of 2013, among the top 10 largest health plans, four were non-investor owned[29]:

- Kaiser Foundation Group, with group model HMOs in nine regions.
- Health Care Services Corporation, the largest mutual health insurer (i.e., owned by its enrollees), with BCBS plans in five states.
- Highmark Group, with BCBS plans in three states.
- EmblemHealth in New York, a company formed through a combination of GHI and the Health Insurance Plan of Greater New York.

Provider Consolidation and the Appearance of Integrated Delivery Systems

Among physicians, there was a slow but discernable movement away from solo practice and toward group practice in the 1990s. There was nothing slow, however, about the amount of hospital consolidation that began on a regional or local level in the 1990s. According to a study conducted by the Rand Corporation, more than 900 mergers and acquisitions occurred during the 1990s, and by 2003 90% of the metropolitan areas in the country were considered "highly concentrated" in terms of healthcare systems.[30] Hospital and health system mergers and consolidations continued after that study was published and continues even now.

Hospital consolidation was commonly justified in terms of its potential to rationalize clinical and support systems. A clearer impact, however, has been the increased market power that enables such entities to negotiate favorable payment terms with commercial health plans (see Chapters 3 and 4). Consolidation also meant that health plans could no longer selectively contract with individual hospitals. Systems with "must have" hospitals or even "must have" services, such as very specialized cardiac or oncology services, could refuse to enter into contracts that did not cover all of the services that the health system offered. As a result, hospital prices to private payers rose by a total of 20% nationally between 1994 and 2001 and by 42% between 2001 and 2008.[31]

Consolidation, both among health plans and providers, diminished competition to the point of bringing into question the viability of the competitive model in the delivery of healthcare services. Instead of competition among multiple buyers and sellers, what evolved was closer to what economists call "bilateral oligopolies" and in a few cases, "bilateral monopolies" with a few large health plans and provider health systems in local markets having little choice but to reach agreements with each other.

Provider consolidation was not the only response to managed care. In many communities, hospitals and physicians collaborated to form integrated delivery systems (IDSs), principally as vehicles for contracting with payers and with HMOs in particular.

Most IDSs of the time were rather loose organizations consisting of individual hospitals and their respective medical staff, the

most common of which was the physician–hospital organization (PHO). Most PHOs and IDSs required that health plans contract with all physicians with admitting privileges at the hospital that met the HMO's credentialing criteria, rather than with only the more efficient ones. Indeed, under the fee-for-service method of payment, physicians with high utilization benefited the hospital financially. Also, physicians were commonly required to use the hospital for outpatient services (e.g., for laboratory tests) that might be obtained at lower cost elsewhere.

Some hospitals chose to purchase PCP practices to increase their negotiating leverage with HMOs, although they did little to integrate those practices.* Most IDSs of the time suffered, at least initially, from organizational fragmentation, payment systems to individual doctors that were misaligned with the goals of the IDS, inadequate information systems, inexperienced managers, and a lack of capital. In addition, hospitals that had purchased physician practices quickly discovered that physician productivity declined once the doctors were receiving a steady income, even with incentives to enhance volume, because they no longer felt the financial pressures of independent practice. In most cases, those practices became a financial drag on the hospital and were eventually spun off at a net loss. Health systems then avoided buying physician practices or employing them for years afterwards, but as we shall see, this strategy reappeared in the following decades and was more successful.

At the time, some health systems sought to "cut out the middleman" and become risk-bearing organizations themselves—a decision they would soon regret. Provider organizations lobbied hard to be allowed to accept risk and contract directly with Medicare. The Balanced Budget Act of 1997[32] (BBA 97)† permitted them to do so as provider-sponsored organizations (PSOs) if they met certain criteria. With a few exceptions, these efforts failed and the PSOs lost many millions of dollars in a few short years. The federal waiver program for PSOs has expired, and only a handful exists today.‡

Some IDSs and provider systems pursued another route to accepting full risk by forming a licensed commercial HMO. The existence of hospitals, physicians, and a licensed HMO and/or PPO under one corporate umbrella is called vertical integration. For a while, this model was touted as the future of health care.

Like so many future scenarios confidently predicted by pundits, it mostly did not happen. Instead, provider-owned HMOs mostly failed for the same reasons PSOs failed—namely, the system was conflicted by, on the one hand, the need to promote volume for patients under the fee-for-service system and, on the other hand, the desire to be efficient in the delivery of services to capitated patients. Not all vertically integrated organizations failed, however. Those that did succeed typically managed their subsidiary HMOs as stand-alone entities. Many HMOs started by large, well-run medical groups also did well and continue to do so today. The rest were sold, given away, or ceased to operate.

Many large provider systems and physician practice management companies nevertheless accepted global capitation risk from HMOs, entailing their receiving a percentage of premium revenues (e.g., 80%) in return for being at risk for most covered medical services. Most of those also failed, and with the exception of many of the large medical groups in California, the number of provider systems contracting to accept full risk for medical costs dropped dramatically.

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* In some cases, physicians became direct employees, but in other cases they were employed by a captive medical group controlled by the hospital; see Chapter 2.

† The BBA 97 also reduced payments to Medicare HMOs, which led to a decline in Medicare HMO enrollment in the early 1990s.

‡ The acronym "PSO" was recycled by Medicare and it now stands for "Patient Safety Organization."

Utilization Management Shifts Focus

As hospital utilization became constrained, the focus of utilization management shifted to encompass the outpatient setting including prescription drugs, diagnostics (which have become increasingly expensive with the development of new technologies), and care by specialists. Perhaps even more important was the recognition of the large expense incurred by a small number of patients with chronic, and often multiple, conditions, resulting in significantly more attention being paid to these high-cost patients.

The role of the PCP also changed. In a traditional HMO, that role was to manage a patient's medical care, including access to specialty care. This "gatekeeper" function was a mixed blessing for PCPs, who at times felt caught between pressures to reduce costs and the need to satisfy the desires of consumers, who might question whether the physician had their best interests at heart in light of a perceived financial incentive to limit access to services. Likewise, patients might resent the administrative hassle entailed in needing the PCP's referral. The growth of PPOs as compared to HMOs also led to a shift away from PCP-based "gatekeeper" types of plans. However, most plans (including PPOs) continued to set lower copayments for services delivered by a PCP rather than by a specialist, thereby retaining a primary care focus.

The focus of utilization management was also sharpened through the growth of carve-out companies—that is, organizations that have specialized provider networks and are paid on a capitation or other basis for a specific service. Among services that lend themselves to being "carved out" are prescription drug benefits as well as behavioral health, chiropractic, and dental services. The carve-out companies market principally to health plans and large self-insured employers because they are generally not licensed as insurers or HMOs and, therefore, are by law limited in their ability to assume risk. In recent years, some of the large health plans that contracted for such specialty services have reintegrated them, when carved-out services made it difficult to coordinate services and/or because the plans had grown large enough to manage the services in question themselves.

Industry Oversight Spreads

Health insurance and managed care have always been subject to oversight by state insurance departments and (usually) health departments. The 1990s saw the spread of new external quality oversight activities. Starting in 1991, the National Committee for Quality Assurance (NCQA) began to accredit HMOs. This organization was launched by the HMOs' trade associations in 1979 but became independent in 1990. The majority of its board seats are now held by representatives of employers, unions, and consumers rather than health plans. Interestingly, this board structure was proposed by the Group Health Association of America, which represented closed-panel HMOs at the time. Many employers require or strongly encourage NCQA accreditation of the HMOs that serve their employees, and accreditation came to replace federal qualification as the "seal of approval." NCQA, which initially accredited only HMOs, has evolved with the market to encompass a wide range of plan types and services. This is also the case with the two other bodies that accredit managed healthcare plans: URAC* and the Accreditation Association for Ambulatory Health Care, also known as the Accreditation Association. For further discussion of these organizations, see Chapter 5.

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* URAC is its only name and is no longer an acronym. At one time, it stood for Utilization Review Accreditation Commission.

Performance measurement systems (report cards) were also introduced, with the most prominent being the Healthcare Effectiveness Data and Information Set (HEDIS).* HEDIS was initially developed by the NCQA at the behest of several large employers and health plans. In addition to employers, Medicare and many states now require HEDIS reporting by plans. Other forms of report cards appeared as well in response to market demanding increasing levels of accountability.

At the federal level, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[33] was enacted. Among other provisions, it limits the ability of health plans to (1) deny insurance based on health status to individuals who were previously insured for 18 months or more and (2) exclude coverage of preexisting conditions (i.e., medical conditions that exist at the time coverage is first obtained), though it did not require insurers to offer the same coverage that is typical of large groups.

Another development stems from a provision in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[34] which allows individuals who lost eligibility for employment-based group coverage (or due to other qualifying events) to continue that coverage for up to 18 months. COBRA enrollees are generally required to pay the full cost (i.e., with no employer or other subsidies) plus a 2% administrative fee. (Coverage continuation is addressed in Chapter 6.) HIPAA was designed in part to provide a means for individuals to have continued access to coverage once they exhausted their COBRA benefits. COBRA had only limited success because the coverage was usually expensive, particularly for someone who is newly unemployed. In particular, a young healthy person could obtain coverage as an individual for less than the group rate, which was priced to include all individuals in the group, including older ones, who on average consume more services.

Until guaranteed issue requirements went into effect in 2014 under the 2010 Patient Protection and Affordable Care Act (ACA),[35] continued coverage under HIPAA was the only way a person with serious medical problems could purchase insurance, but it was expensive and usually only those with serious medical conditions obtained it. More important to the industry were the standards that HIPAA created for privacy, security, and electronic transactions.

The Managed Care Backlash of the Late 1990s

Anti-managed care sentiment, commonly referred to as the "managed care backlash," became a defining force in the industry as the United States approached the new millennium.[36] As a society, Americans expected managed care to reduce the escalation of healthcare costs but became enraged at how it did so. In retrospect, why that happened is obvious: Managed health care was the only part of the healthcare sector that ever said "no." The emotional overlay accompanying health care outstrips almost any other aspect of life. The health problems of a spouse or child cause feeling in ways that a house fire or even losing one's employment does not.

The roots of the backlash date back to the late 1980s and early 1990s. At that time, most employers allowed their employees to choose between an HMO and a traditional health insurance plan, although their payroll deduction was typically higher if they chose the traditional health plan. Eventually, to control costs, many employers began offering

* HEDIS initially stood for Health Plan—Employer Data Information Set.

employees managed care plans exclusively, with no option to buy traditional insurance.

One source of contention with some consumers—particularly those who had not chosen to be in an HMO—was the requirement that they obtain authorization from their PCP to access specialty care. Arguably, this provision both reduces costs and increases quality by assuring that PCPs are fully apprised of the care that their patients receive. Another source of contention was that consumers under the care of a specialist who was not in the HMO's network were required to transition their care to an in-network doctor—another burden resented by individuals who had not voluntarily chosen to be in an HMO.

There was more to the backlash, however. As noted earlier, rapid managed care growth increased the risk of problems. Some of the problems were largely irritants, such as mistakes in paperwork or claims processing in health plans with information systems that were unable to handle the expanded load. Rapid growth also affected the ability to manage the delivery system. Where clinically oriented decisions on coverage were once made with active involvement of medical managers, some rapidly growing health plans became increasingly bureaucratic and distant from both their members and their providers, causing the plans to be seen as cold and heartless, and the errors and delays in payment as intentional.

Sometimes, rapid growth led to inconsistent coverage decisions. The public's perception that decisions regarding coverage of clinical care were made by "bean counters" or other faceless clerks may not have been fair or accurate in the opinion of managed care executives, but neither was it always without merit. Some HMOs, especially those whose growth outstripped their ability to manage, did delegate decision-making authority to individuals who lacked adequate training or experience and were not supported by the comprehensive algorithms and well-documented benefits determination policies that are common today (see Chapter 5). Furthermore, some plans were accused of intentionally denying or delaying payment of claims, caving in only when the member appealed—an accusation disputed by the plans. Regrettably, the managed care industry during this period did a poor job of self-policing and lost the confidence of large segments of the public.

Other problems were emotional and not a threat to health, such as denial of payment for care that was not medically necessary—for example, an unnecessary diagnostic test or an additional day in the hospital. For doctors and patients who are unaccustomed to any denial of coverage, these actions were commonly viewed as overzealous utilization management, which, indeed, in some instances they were. The frequency of these types of denials is not known.

Finally, while uncommon, some problems did represent potential threats to health such as difficulties in accessing care or denial of authorization for payment for truly necessary medical care, thereby causing subsequent health problems. Sometimes, the denial was due to the care not being a covered benefit, as in the case of certain experimental procedures. This occurred with indemnity health insurance as well but was not viewed the same way. The public expects low premiums but demands coverage for all medically related services, including ones that might be judged unnecessary or outside of the scope of the defined benefits; the public also expects access to any provider an individual chooses to consult.

Whether a service is medically necessary or simply a convenience can be a matter of interpretation or dispute. Is a prescription for a drug to help with erectile dysfunction medically necessary? What about growth hormone therapy for a child who is short because her or his parents are short, not as a result of a hormonal deficiency? Should fertility treatments be unlimited? Some interventions may be medically necessary for some patients but not others. For example, in a patient with droopy eyelids but no impairment of vision, surgery is primarily cosmetic, although it

often progresses until it is medically necessary because vision is impaired.

The most damning of all accusations was that health plans were deliberately refusing to pay for necessary care to enrich executives and shareholders—a perception enhanced by media stories of multimillion-dollar compensation packages of senior executives. Putting aside the fact that financial incentives drive almost all aspects of health care to varying degrees, this charge was particularly pernicious for health plans in light of the increasing number of for-profit plans.

Serious, even if isolated, problems make good fodder for news using the well-proven reporting technique of "identifiable victim" stories in which actual names and faces are associated with anecdotes of poor care or problems accessing coverage. Whether the problems portrayed were fair was irrelevant. When added to the disgruntlement caused by minor or upsetting (although not dangerous) irritants, the public was not liable to be sympathetic to managed care, particularly given the backdrop of the negative image of the insurance industry.

Politicians were quick to jump on the bandwagon, especially during the debate over the Health Security Act of 1993, legislation proposed by President Bill Clinton but not enacted. Many states passed "patient protection" laws specifying prudent layperson standards for emergency care, similar to what was eventually included in the ACA; stronger appeal and grievance rights; and requirements for HMOs to contract with any provider willing to agree to the HMO's contractual terms and conditions. Whether the "any willing provider" provision protects consumers is debatable, and not all states passed laws to require it. Most states did pass laws requiring prudent layperson standards and appeal rights, which later were also incorporated into the Affordable Care Act.

Another example of a "patient protection" law that arose out of the managed care backlash was the prohibition of "gag clauses" in HMO contracts with physicians in which an HMO's contract supposedly prevented a physician from informing patients of their best medical options. So prevalent was the belief that such constraints existed that it made the cover of the January 22, 1996 edition of Time magazine, showing a photo of a surgeon being gagged using a surgical mask and a headline that read "What Your Doctor Can't Tell You. An In-Depth Look at Managed Care—And One Woman's Fight to Survive."*

The Government Accountability Office (GAO), an agency of the U.S. Congress, investigated the practice at the request of then-Senators Lott, Nickles, and Craig and issued its report on August 29, 1997. The GAO reviewed 1,150 physician contracts from 529 HMOs and could not find a single instance of a gag clause or any reported court cases providing guidance on what constitutes a gag clause.[37] This report had no impact on public perception, however. Laws prohibiting "gag clauses" became widespread, and years later this prohibition was also incorporated into the ACA.

The popular press continued to run regular "HMO horror stories." For example, the cover of the July 12, 1998 issue of Time magazine

* The cover story was titled "Medical Care: The Soul of an HMO" and dealt with a woman's dispute with a California HMO over coverage for a procedure for her disseminated breast cancer, known as autologous bone marrow transplantation. Coverage was denied because the treatment was considered experimental and investigational by a committee of the HMO's private oncologists. The story reported a considerable amount of communication, meetings, phone calls, medical visits and so forth, as well as the salaries and bonuses of HMO executives. There was no example or even mention of a "gag clause."

The woman sued and succeeded in getting the procedure covered, and an arbitration panel awarded her family punitive damages from the HMO. This case was only one of a number of lawsuits that finally forced HMOs and insurers to pay for this procedure. The woman died soon after the procedure was performed. Rigorous scientific study of autologous bone marrow transplantation eventually found that the procedure was no better and potentially worse than conventional treatment alone, and it is no longer performed.

showed a photo of stethoscope tied in a knot and a headline that read "What Your Health Plan Won't Cover…" with the word "Won't" in large bold red letters. In another example, the November 8, 1999 cover of Newsweek magazine featured a furious and anguished woman in a hospital gown and clenching her face and hands, and with the words "HMO Hell" displayed across the image. HMOs were disparaged in movies, cartoons, jokes on late night TV, and even the comic sections of newspapers. The number of lawsuits against HMOs increased, with many alleging interference in doctors' decision making. Many also alleged that capitation incented physicians to withhold necessary care, although this charge lacked empirical support, as shown in research studies discussed in Chapter 4.

In a futile attempt to counter the rising tide of antipathy, the managed care industry repeatedly tried to point out the good things it did for members such as coverage for preventive services and drugs, the absence of lifetime coverage limits, and coverage of highly expensive care—but there was nothing newsworthy about that. A reporter for a major newspaper, who did not himself contribute to the backlash, said at the time to one of this chapter's authors, "We also don't report safe airplane landings at La Guardia." (La Guardia is one of the New York City area airports).

In response to public complaints, HMOs expanded their networks and reduced how aggressively they undertook utilization management. Some eliminated the PCP "gatekeeper" requirement, thereby allowing members open access to any specialist, albeit at higher copayment levels than applied visits to the PCP. To borrow words used a decade earlier by President George H. W. Bush in his inaugural address, HMOs became "kinder and gentler," and healthcare costs began once again to rise faster than general inflation or growth in the GDP.

The managed care backlash eventually died down. The volume of HMO jokes and derogatory cartoons declined, news stories about coverage restrictions or withheld care became uncommon, and state and federal lawmakers moved on to other issues. However, the HMOs' legacy of richer benefits combined with the general loosening of medical management and broad access to providers collided with other forces by the end of the millennium, and cost inflation returned, leading to an increase in the number of uninsured and greater cost sharing for those with coverage.

2000–2012: HMOs and POS Plans Decline in Enrollment, Costs Grow, and Coverage Erodes

Economic growth was steady early in the first decade of the new millennium, but healthcare costs rose faster than the economy as a whole, increasing from 13.8% of GDP in 2000 to 16% in 2005.[38] As the economy began to slow in the second half of the decade, the healthcare cost increases diminished for a short period in time. However, in 2009, as the United States entered the "Great Recession," healthcare costs reached 17.6% of GDP. The U.S. economy may have become stagnant, but the healthcare sector was not.

In the early 20th century, healthcare costs were driven by common occurrences such as infections, trauma, and increasingly on surgical treatments. That began to change around mid-century when advances in medical science allowed us to treat conditions that were once untreatable. Over the decades this also led to longer lifespans, including those with multiple chronic conditions.

At the end of the 20th century, approximately 80% of total costs were being incurred by only 20% of individuals, and 50% of costs by only 5%. At the same time, obesity has become more common, as have other health

conditions. Healthcare cost increases reflected a variety of other factors too, including the decline in HMO market share, looser utilization management, the adoption of new and expensive (and often unproven) technologies, increased consumer expectations, direct-to-consumer marketing, the provider community's quest for new sources of income, pricing increases, and the practice of defensive medicine by providers who feared malpractice suits.

During this 12 year period, many employers responded to the tight economic situations by increasing deductibles and other forms of cost sharing and, in some cases, dropping employee coverage altogether. For some people in the individual market, health insurance became unaffordable, and healthcare costs strained many family budgets. What was not seen in those years was movement back towards more tightly managed care as has occurred after the passage of the ACA (often now referred to as "Obamacare").

The Decline of HMO and POS Market Share

HMOs' share of the commercial enrollment market stood at 29% in 2000. It declined thereafter, reaching 25% in 2004, and then hovered around 20%–21% from 2005 to 2009, before dropping further to 13% by 2014. POS plans, which had enjoyed a 24% market share in 1999, also steadily declined but then leveled out at around 10% by 2009. PPOs, in contrast, gained market share—growing from 39% in 1999 to 61% by 2005, before declining slightly after 2009.[39] More recently, HMOs have increased and PPOs have decreased share, but by small amounts.

Managed Care in Medicare and Medicaid

Medicare managed care enrollment also reversed itself, declining from 6.4 million in 1999 to 4.6 million by 2003.[40] This trend occurred largely as a result of a provision in the Balanced Budget Act of 1997 that reduced what Medicare paid the health plans, resulting in increased premiums, making the plans less attractive to Medicare beneficiaries. In markets where Medicare costs were low, the blanket reduction led many Medicare HMOs to exit the market.

However, the situation changed with the enactment in 2003 of the Medicare Modernization Act (MMA),[41] which increased payment to managed care plans from below the estimated cost of delivering services in the fee-for-service system to an amount that in years leading to the ACA exceeded 10% of what Medicare would have spent had enrollees remained in the fee-for-service system. The MMA also changed the name of the Medicare managed care program from Medicare+Choice to Medicare Advantage (MA) and promoted new forms of managed care such as Private Fee-for-Service (PFFS) plans, which were more like traditional insurance policies than HMOs. Their financial viability depended on Medicare's paying the plans more than would be paid for the same enrollees in standard Medicare. PFFS plans rapidly expanded and then disappeared just as fast after 2003 when payment was made to approximate standard Medicare levels and new network and reporting requirements were adopted. During this time, MA enrollment grew to 13.1 million by 2012, and HMOs remained the largest form of MA plan, accounting for approximately 64% of all MA enrollees.[42]

The MMA also created the first major benefit expansion in Medicare since the passage of the initial legislation in 1965: The Part D drug benefit. Interestingly, rather than paying for the benefit on a fee-for-service basis as in traditional Medicare, the government capitated private pharmacy benefits managers (see Chapters 5 and 7), which are companies that specialize in processing drug claims; others were insurers or HMOs that had the same capability. This method of administering the Part D benefit was intended to provide beneficiaries with a choice among competing plans.

Existing MA managed care plans were also required to offer at least one plan that incorporated the drug benefit. Providing the new drug coverage benefit entirely through private companies was controversial, in part because it had never been done before. It was also regarded by some at the time as unworkable. Nevertheless, Medicare Part D's benefit has survived and even thrived, albeit with administrative problems at the beginning.

Growth in the Medicaid managed care program followed a smoother trajectory. Cash-strapped states increasingly turned to private managed care plans. In 2000, 56% of Medicaid recipients were in some form of managed care, but not always in a comprehensive managed care plan (see Chapter 7); by 2012 the total rose to 75%, of which 56% were in comprehensive plans.[43] Those figures have grown substantially since then.

The Toll of Rising Healthcare Costs

The toll of rising healthcare costs on the economy in the first decade of the new millennium was considerable.[33] In the commercial group market, employers continued to pay approximately 70% of the cost, with the remainder coming from payroll deductions, although many increased deductibles, copays, and/or coinsurance.* However, with healthcare costs rising so rapidly, employees' absolute dollar contribution rose considerably. Rising costs, along with a weakened economy, resulted in the percentage of Americans without health insurance rising from 14% in 1999 to 17% in 2009.[44] One reason was that some businesses, particularly small ones, found coverage to be unaffordable. Another reason was greater number of employees declining employer-sponsored coverage to avoid the payroll deduction. Although statistics vary, bankruptcies resulting from medical debt during this period were also widely estimated to account for more than half of all personal bankruptcies. Cost sharing in benefits design is addressed in more detail in Chapter 2, and management of the drug benefit is discussed in Chapters 4 and 5.

The middle of this decade also saw the appearance of high-deductible health plans (HDHPs) and related consumer-directed health plans (CDHPs), which confer savings in federal income taxes provided that they have deductibles that are above a pre-set minimum, amounting in 2014 to $3300 for individuals and $6500 for families. Further discussion of HDHPs and CDHPs is found in Chapter 2.

Embedded in CDHPs is the notion that consumer choice and accountability should be enhanced. The initial focus was to provide members with better information regarding quality and cost of care along with information on how to navigate the healthcare system. Such plans are controversial because, whatever the resulting savings, people with high incomes disproportionately gain from tax savings because they are in higher tax brackets, whereas persons with high medical expenses—notably those individuals with chronic conditions—face substantially higher out-of-pocket expenses, often year after year. However, with the rise in premium costs, these products have become the only affordable options for many people.

2012: The Patient Protection and Affordable Care Act

The ACA, signed into law on March 23, 2010, is the most sweeping healthcare legislation passed in the United States since the enactment of Medicare and Medicaid in 1965. It is also the most important legislative development in the health insurance and managed care industry to occur in this millennium.

* Larger employers typically contribute more than do smaller employers.

At nearly 1000 pages in length, the ACA affects the entire healthcare sector, but its two areas of greatest impact are on the health plan industry and access to coverage. Because the ACA is so sweeping, it is not possible to cover it all within the confines of this text, much less in this chapter. The most important provisions of the ACA are addressed throughout this text and included the following:

- Health benefits plans are required to cover dependents until age 26.
- Health insurance and HMO coverage are required to be "guaranteed issue," meaning health plans cannot deny coverage or vary premiums based on preexisting conditions or health status. Premiums can, however, reflect geographic location, age (within prescribed limitations), and tobacco use. Guaranteed issue is confined to an annual limited period of "open enrollment" when individuals and small groups can apply for coverage.*
- Health insurance "exchanges" are established by individual states, or by the federal government if a state does not do so. Such exchanges are essentially computer-based systems where individuals and small businesses can purchase insurance from private health plans.
- All Americans not otherwise covered were required to purchase an approved private insurance policy or pay a penalty, with some exceptions; the most important being individuals deemed to be subject to undue hardship as a result. The individual requirement, which was vehemently opposed by most Republicans as an infringement on personal liberties, is commonly attributed to the Heritage Foundation, a conservative think-tank; the Foundation proposed this concept in 1989, and it was supported by many Republicans at the time. The individual mandate was eliminated by Congress as of 2019.
- Individuals and families with incomes greater than 133% but less than 400% of the poverty level who are not eligible for Medicaid can qualify for premium and cost sharing subsidies (see Chapter 2).
- The Medicaid program was expanded to cover all families and individuals with incomes of less than 133% of the federally established poverty line, with the federal government paying states 100% of the cost of covering the expansion population in 2014–2016, declining gradually to 90% in 2020 and thereafter. Many states did not expand Medicaid eligibility, however, for the following reasons.

The ACA, which passed narrowly, was the subject of a hard-fought battle prior to its enactment and remains controversial. Lawsuits pertaining to its legitimacy reached the U.S. Supreme Court after being litigated in lower courts. The two main Supreme Court decisions, both reached on five to four votes, were that the mandate that individuals obtain health insurance was constitutional because it was a tax, but not the requirement that states expand their Medicaid programs as a condition for receiving any federal matching funding. According to the Kaiser Family Foundation, as of January 2018, 33 states including the District of Columbia, had adopted the Medicaid expansion; Virginia passed expansion in 2018 to be effective 2019; Nebraska, Utah and Idaho voted to expand by referendum; and some of the remaining states were considering it.

Taken as a whole, the provisions of the ACA had the effect of expanding the number of individuals in both Medicaid and private healthcare plans—one reason why the health insurance industry was generally supportive of the legislation. It is also the reason that, despite holding the majority in both houses

* The ACA requires that open enrollment periods be no less than one month per year, which occurs in the fall for coverage beginning the following January 1. States are free to require open enrollment on a more frequent basis, including continuous open enrollment, but none have done so.

of Congress as well as the presidency, Republicans were (narrowly) unable to "repeal and replace" the ACA despite having uniformly pledged to do so once they were in power.

The ACA continues to face political and legal challenges and will continue to be amended. For example, in December 2017, major changes to the tax code were enacted, including eliminating the individual penalty for not obtaining insurance starting in 2019; but at the time of publication twenty states are challenging this in court as being unconstitutional and a basis for the court to overturn the ACA.

In another example of a political challenge, while the federal government subsidizes premiums for individuals and families that qualify, the ACA requires health plans that participate in the exchanges to reduced out-of-pocket cost sharing to enrollees below 400% of the poverty line. But Congress has refused to fund the cost to health plans for reduced cost-sharing, resulting in carriers having to increase premiums by an estimated 8%–10% to break even financially, as described more fully in Chapter 6. How many plans will continue to offer coverage and whether the resulting premiums will be so high as to dry up demand is an open issue. At the time of publication, Congress was debating restoring the cost sharing reduction subsidies and/or having the Federal government reinsure high cost patients in order to stabilize the health insurance market, but had not acted, and the administration had taken other actions described in this text where appropriate.

The Healthcare Market Never Stops Changing

As important as is the ACA, it is not the only development of note. The healthcare market continues to evolve, in some cases mirroring events of 15 or more years ago.

Accountable Care Organizations

The ACA authorized the creation of accountable care organizations (ACOs), which are described more fully in Chapters 3 and 4. ACOs are provider entities that assume partial financial risk for cost increases of the Medicare Part A and Part B benefits for a defined population of beneficiaries in the traditional Medicare fee-for-service program.* The formula for the sharing of risk reflects a target that is intended to approximate what would have been spent absent the ACO agreement. Bonuses are paid only if the ACO meets both cost and quality performance standards. This is described further in Chapter 4.

What is unique about this arrangement is that Medicare beneficiaries are attributed to the ACO based on past utilization patterns rather than their choosing to enroll. Those beneficiaries can use any Medicare participating provider, unlike in an HMO. In fact, the ACO may be invisible to the beneficiary. The ACO program was included in the ACA as a permanent (not a pilot) program, despite its being an untested model at the time.

Some of the early ACOs have dropped out over what they perceive as long delays in the Government's provision of data that determine whether they met the expenditure targets, skepticism of the accuracy of the data, and a sense that the formula was unfair, particularly in low cost areas. Even more dropped out because the savings did not exceed the CMS threshold, particularly as that threshold did not reflect the administrative costs that the ACOs incurred, mostly for cost management.

However, participation in the ACO program has continued to grow. As of 2018, there were more than 561 ACOs (most did not share risk) accountable for 10.5 million beneficiaries

* They may not be required to share risk during their initial years of operation.

in the traditional FFS Medicare program. In 2016 about one-third of ACOs at the time collectively earned $700 million in performance bonuses.[45]

Physician Employment by Hospitals and Health Plans Makes a Comeback

As described earlier in the chapter, during the late 1980s and through the mid-1990s, group and staff model HMOs declined in prominence. At the same time many hospitals that felt threatened by managed care reacted by purchasing physician private practices, mostly those of PCPs but of some other specialties as well. The intent was to make it difficult for an HMO or PPO to exclude the facility in question from its network and to gain negotiating strength by employing the PCPs whom health plans most needed. For most hospitals, the earlier expansion was a costly effort that was subsequently reversed.

The strategy of hospitals' employing physicians (directly or indirectly through a captive medical group) has returned in recent years as hospitals have consolidated to create major health systems. In some cases, the hospitals have once again purchased practices; in other cases, physicians are seeking direct employment and do not have a practice to sell, such as those who recently finished their training programs. Physicians increasingly find it attractive to be employees because they require predictable income to repay student debts, seek more control of their lifestyle, or do not want the burden of practicing privately. One example of a new burden is government efforts to induce providers to adopt electronic medical records, which are beneficial but are also costly and time consuming for the provider to learn to use when first installed. Another example of a new burden are the reporting requirements for the new and complicated payment methodologies introduced by Medicare.

Physician employment by hospitals grew by 49% between 2012 and 2015, and more than 140,000 physicians were employed by hospitals by 2015.[46] However, the AMA reports that the trend of hospitals' acquiring physician practices leveled out in 2016, reporting that the percent of physicians in hospital-owned practices or who were employed directly by a hospital was the same in 2016 as in 2014 (32.8%) but higher than in 2012 (29.0%).[47]

Some healthcare systems employ more than 1000 physicians—numbers that were unheard of the last time this strategy was attempted. The consolidation that is occurring brings into question the viability of the competitive model when large provider systems dominate the market, leaving insurers little opportunity to select the providers with whom they contract.

The preponderance of evidence is that when hospitals employ physicians, costs increase. For example, a study published in 2014 reported that, compared to physician-owned organizations or practices, costs were 10.3% higher for single hospital-owned practices, and 19.8% higher for practices owned by multi-hospital systems.[48] Similar findings have been reported in other studies. Unfortunately, these higher costs have not been associated with demonstrated improvements in quality.[49]

As with hospitals, health plans have also increasingly employed physicians although hospital employment of physicians is by far the more significant dynamic. Health plans have done so in some cases to ensure that they would have network physicians who were not employed by a hospital and in other cases to create an alternative for medical groups that did not want to become part of a large hospital system.

At the time of publication, for example, United Healthcare, the largest health plan apart from the Blues, had entered into an agreement to acquire the physician practices owned by DaVita. These practices include such large multi-site medical groups as HealthCare Partners in California, the Everett Clinic in Washington State, and New West in Colorado. This

acquisition would add to the 30,000 physicians already working for United. Also, CVS, the drug store chain, and Aetna, a large insurer, have proposed to merge, the presumption being that the combined company would build out the urgent care and primary care clinics of CVS.

Narrow Networks

During the heyday of early HMO growth in the 1970s and early to mid-1980s, the expectation among many pundits (including the authors) was that managed care plans would select providers based on their efficiency, resulting in relatively small provider networks in comparison to the total number of physicians in a geographic area. This did not come to pass. Indeed, particularly after the managed care backlash, health plans broadened their networks by accepting, or being forced by state law to accept (see Chapter 3), any providers into their networks who met the health plan's terms and requirements.

Stimulated by the ACA, the strategy of having a broad network changed, at least for some health plans or for some of their products. Specifically, many health plans participating in the state and federal insurance exchanges are being selective in terms of who they accept as participating providers. In those cases, the networks for the products being offered in the exchanges are smaller than those offered to large employer groups. The goal of these health plans is to manage better the costs and utilization associated with providing coverage to individuals with significant medical problems. In some cases, where health plans employ physicians, the network is restricted in order to drive volume to those physicians.

The limitations in network size have rankled many consumers and consumer activist organizations as well as some state regulators. Some states are considering requiring plans that participate in their exchanges to offer out-of-network benefits with higher cost sharing. So far, only a few states have required this type of benefit design.

Conclusion

In the later part of the 2010s, managed care remains dominant. For example, according to the Kaiser Family Foundation, in 2016, among employed populations only 1% of covered workers were in what is classified as traditional insurance. In contrast, 48% were in PPOs, 15% in HMOs, and 8% in POS plans. The remaining 29% were in HDHPs as described earlier.[50] In addition, one-third of all Medicare beneficiaries are in Medicare Advantage plans, mostly in HMOs, a percent that has increased steadily in recent years despite payment reductions provided for in the ACA.

Managed health care has affected the delivery system in significant ways—many positive, but some negative. HMOs, for example, demonstrated that many procedures that were once performed only on an inpatient basis could be performed equally well in an outpatient setting. HMOs also showed that inpatient length of stay could be reduced without ill effect. Over time, these changes have become the norm of practice, including in the fee-for-service system. Likewise, HMOs' early emphasis on prevention is now reflected in certain laws including those pertaining to the ACA and Medicare.

The early HMOs were also the source of considerable research on quality of care, far more so than the unmanaged fee-for-service system. This research contributed to policy makers' and large employers' becoming comfortable contracting with them. Furthermore, it helped accelerate the overall broadening of quality measurement and management beyond the hospital setting to which it had traditionally been confined.

The initial and ongoing public and regulatory mistrust of managed health care and health insurers in general led to the creation of standard measures to evaluate health plans.

Most notable among these measures are the HEDIS and the Consumer Assessment of Health Care Providers and Systems survey (see Chapter 5).

Of note is the synergistic relationship between the public and private sectors. HMOs, which are private entities, have proved themselves to be viable mechanisms for delivering care to Medicare and Medicaid beneficiaries. Government at all levels has stimulated managed care growth in other ways as well. One of the earliest examples of a large employer contract with HMOs on a dual-choice basis was that between the U.S. Office of Personnel Management and the Kaiser Foundation Health Plans, an approach that was subsequently adopted by many large employers. Today, federal, state, and local government employees constitute the largest accounts of many managed care plans. In addition, the HMO Act of 1973 spurred HMO development through grants, loans, and, most importantly, the dual choice mandate. Finally, many health plans have adopted Medicare's methodology for paying physicians and, less commonly, hospitals.

On a negative note, the managed care industry did not respond well to the managed care backlash of the late 1990s. At the time, it did not make sufficient efforts at self-regulation, although many health plans were supportive of the NCQA. At first, the industry handled the backlash as a public relations problem. In opposing legislation to address the backlash, managed care plans opposed what most people viewed as sensible requirements, notably the layperson emergency rule and the right to appeal coverage denials to an independent body, giving the impression that the managed care industry was putting money ahead of patient care.

Rising costs meant rising numbers of uninsured individuals, which was the impetus behind the passage of the ACA in 2010. The lingering negative view of health insurers and managed care played a prominent role in the debate and the ACA's ultimate passage. Whether the ACA will accomplish its intended goals is unknown, but it is fair to say that its primary focus is on ensuring access to health insurance and not on restraining costs.

The issue of cost containment continues to be featured prominently in the media. Unfortunately, many persons have their "silver bullet" to solve the costs problems: if we could only solve the malpractice problem OR if we could only institute higher cost sharing so that patients would seek out efficient providers OR if provider payment could be changed to avoid the incentives in fee-for-service plans to deliver more, and more expensive, care OR if competition in health care could be enhanced OR fill-in-your-favorite-solution-here. Each of these measures has a place as part of a comprehensive strategy, as do other approaches such as promoting wellness and addressing the problem of untested, questionable, and marginally effective technologies. In the past several years, attention has also been focused on pricing by providers and drug manufacturers, but such reports have so far generated little more than a brief flurry of indignation before fading away.

An inherent problem in controlling healthcare costs is that one person's cost is another person's revenues—and providers seeking to protect their incomes are better organized than are patients or, for that matter, the citizenry as a whole. In addition, at the time of needing services, patients have little concern with costs. For their part, politicians commonly issue demagogic statements identifying any limitation as "rationing," hampering informed public discussion. Health plans can do only so much. In the short run, they must respond to the desires of their customers—individuals, employers, or unions—who themselves may be neither willing to address the issues nor well informed.

Health plans must also respond to state and federal regulators as well as changing ACA requirements, and those regulators may likewise be unwilling or unable to address cost concerns. Managed health care has and will continue to make important contributions, but it is not the panacea some had hoped for.

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CHAPTER 2

Health Benefits Coverage and Types of Health Plans and Payers

LEARNING OBJECTIVES

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

Introduction

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

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

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

coverage and who may or may not be patients.

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

The fundamental obligation of any payer is to manage covered benefits for healthcare goods and services, meaning which goods and services will be paid for and under which circumstances, how much will be paid by the benefits plan when something is covered, and how much will be paid by the member who is covered under that plan. This simple description, however, quickly becomes complex in the real world made up of different types of payer organizations.

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

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

The clear distinctions between types of payers have become somewhat blurred over time, and organizational elements and features that had appeared previously in only one type of payer have found their way into other types of payers; it is one reason the term MCO remains in use. For this reason, as well as to avoid getting bogged down, this book will refer to these organizations collectively as "payers," "health plans," or even "plans" when addressing them broadly but will identify the specific types of payers when it is important to distinguish between them.

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

Health Benefits Coverage

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

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

The majority of health plans can only manage what services it will and will not pay for and under which circumstances. In other words, health plans cannot prevent someone from receiving a medical service, but it can determine whether the service will or will not be paid for by the plan, and how much it will pay. This is not to say that health plan benefits coverage policies and decisions have no impact: It is hard to argue that a plan's denial of coverage for a $50,000 elective procedure would have no impact on a person's decision to have that procedure done. Nevertheless, it is useful to keep in mind that health plans manage benefits, meaning payments for medical goods and services, but do not provide the care and cannot prevent a doctor from doing a procedure or a patient from getting a treatment, drug, or device.

There are three interrelated core components of healthcare benefits:

- Defined benefits
- Cost sharing
- Coverage limitations

Defined Benefits

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

This differs from a defined contribution plan, which defines a fixed amount of money that may be put toward a benefit. For example, a defined benefit would be coverage of an inpatient stay regardless of cost. A defined contribution, in contrast, would be coverage of only $250 of the cost of that stay, regardless of what it costs. All types of health plans discussed in this text, as well as in the Patient Protection and Affordable Care Act of 2010 (the ACA),* are defined benefits plans.

Even in a defined benefits plan, the rules and requirements governing when coverage may apply vary by type of health plan. For example, HMOs typically cover nonemergency services only when they are authorized or when authorization is not required per the HMO's policies (e.g., seeing a primary care physician or a gynecologist); they will not cover the cost of nonemergency care provided by non-contracting providers, unless authorized by the HMO, or unauthorized services that require authorization.

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

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

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

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

To review a plan's defined benefits, existing members and individuals looking for coverage are required under the ACA to be provided with a standardized document called the summary of benefits and coverage or summary of coverage. That document also summarizes how the plan defines "medical necessity," meaning how it determines whether coverage is appropriate based on a person's clinical condition and other factors. There is a far bulkier document that members have access to that is called an Evidence of Coverage that has greater detail about the plan, including greater specificity for coverage and medical necessity.

Essential Health Benefits Defined in the ACA

The ACA further defines essential health benefits (EHBs), meaning services or goods that must be covered, but those are defined only at a high level. EHBs apply to individual and small group plans, but the amount of cost sharing or levels of coverage may differ for various plans with one exception: No cost sharing is allowed for preventive and wellness services. **TABLE 2.1** lists the EHBs as defined by the ACA. The ACA also limits plan participation in the insurance exchanges to qualified health plans (QHPs) covering the EHBs. The details of EHBs may differ slightly from state to state for reasons discussed shortly.

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

- Health plans cannot exclude individuals because of a preexisting condition or discriminate based on health status for children younger than age 19.
- They cannot have any lifetime limits on coverage.
- They cannot have any annual limits on coverage.
- They must extend coverage to an employee's dependents until age 26.

The Impact of State-Mandated Benefits and Definitions of EHBs

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

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

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

TABLE 2.1 Essential Health Benefits Under the ACA

Benefit	Cost Sharing Allowed
Ambulatory patient services	Yes
Emergency services	Yes
Hospitalization	Yes
Maternity and newborn care	Yes
Pediatric services	Yes
Preventive and wellness services	No; first-dollar coverage required
Prescription drugs	Yes, but differ from cost sharing for medical benefits
Laboratory services	Yes
Mental health and substance use disorder services	Yes, but may *not* differ from cost sharing for medical benefits
Chronic disease management	Yes
Rehabilitative and habilitative services and devices	Yes

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

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

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

Cost Sharing

Cost sharing refers to the amount of money a member must pay out-of-pocket for each type of covered benefit. It applies only to benefits that are covered by the plan, not to services or goods for which no coverage is offered.

Basic Types of Cost Sharing

The three basic types of cost sharing are as follows:

- *Copayment*, meaning a fixed amount of money per type of service—for example, $30 each time a member goes to the doctor.
- *Coinsurance*, meaning a percentage of the total dollar amount that is covered—for example, 20% of the payment amount to a hospital for an inpatient stay, based on in-network payment rates.
- *Deductible*, meaning a fixed amount of money that a member must pay out-of-pocket before any coverage begins to

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

All three types of cost sharing may be found in a typical health benefits plan. Deductibles and coinsurance may apply to the same benefit, whereas copayments typically apply only for services that are not subject to a deductible. For example, a visit to a primary care physician (PCP) who is in the network of a PPO may have a $20 copayment, while a visit to a physician who is not in the network may be subject to a $500 deductible before the PPO makes any payment, at which point the member must pay 20% of the covered amount as well as any charges over what the plan covers; this is called balance billing and is discussed later in the chapter and in Chapter 3.

Cost sharing may also differ by type of service. For example, PCP visits may have a $20 copayment, whereas a hospital stay may be subject to a $1000 deductible and then 10% coinsurance after the deductible is met. Cost sharing may also differ, and be separately counted, for drug coverage than it is for all other benefits.

Cost Sharing Under the ACA

The ACA defines levels of allowable cost sharing for QHPs and insured coverage (self-funded plans may be somewhat different). For preventive services, the ACA does not allow any cost sharing at all for any type of plan. For other covered benefits as listed in Table 2.1, the ACA defines four basic levels of cost-sharing percentages for EHBs in the individual, group, and insured markets:

- Platinum, defined as 10% or less total cost sharing*
- Gold, defined as 20% total cost sharing
- Silver, defined as 30% total cost sharing
- Bronze, defined as 40% total cost sharing

The ACA also defines a special type of benefits plan that may be offered to individuals younger than the age of 30, which has a higher level of cost sharing but a very low premium.

Cost sharing is based on the average total amount of cost sharing for nonemergency services provided by network providers. In other words, it is the combination of copayments, coinsurance, and deductibles—not just one type of cost sharing. It is based on the average total amount of cost sharing for all members, rather than the amount of cost sharing by any particular member. The percentages also reflect how much a plan pays its network providers, such that members who receive nonemergency care from non-network providers are covered only up to the amount a plan would pay based on in-network services. These different tiers apply only to plans sold to individuals and small groups, but all plans must offer at least 60% coverage regardless of plan type, and as a practical matter these concepts are used by nearly all health plans.

The ACA also limits the maximum out-of-pocket cost for individuals and families, after which no further cost sharing may be applied. The dollar amounts are set by the U.S. Treasury Department each year. For example, in 2019, the maximum out-of-pocket costs in employer-group benefits plans could be no more than $7900 for self-only coverage and $15,800 for family coverage; 2019 HDHP limits are $6,750 and $13,500 respectively. Many health plans actually set their maximum out-of-pocket limits at a lower level, however.

Coverage Limitations

Several different types of coverage limitations exist. For example:

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

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

of coverage for nonemergency services provided by in-network versus out-of-network providers may cover long-term rehabilitative services only when they are provided by a contracted provider.
- The maximum dollar amount of coverage is usually based on what the plan pays providers in its network, not what a provider charges.
- Limits may be placed on the number of services or devices covered in a time period. For example, coverage may be limited to one pair of foot orthotics every 2 years.
- Coverage may be based on medical necessity. For example, the plan may not provide any coverage for care that is experimental or investigational (unless part of an authorized study as defined in the ACA), care that is for the convenience of the patient or provider, care for which a lower cost but equally effective alternative exists, and so forth.
- Some services may not be covered under any circumstances. For example, coverage is usually not provided for people who need custodial care because they cannot care for themselves.

In the past, many plans used to limit coverage to a total dollar amount paid in a year, in a person's lifetime, or both. The ACA, however, prohibits qualified plans from imposing an annual or lifetime limit on coverage.

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

Sources of Benefits Coverage and Risk

The sources of benefits coverage refer to how groups or individuals obtain health benefits coverage, while risk refers to who or what is at risk for the cost of payment for those benefits. These two concepts are closely related but are not identical and are not the same for each group or individual. At its most basic, there are three types of coverage sources and three forms of risk bearing.

Three Basic Sources of Benefits Coverage:

- Entitlement programs
- Individual coverage
- Group health benefits plans

Three Broad Forms of Risk Bearing:

- Government bears the risk
- Payer bears the risk
- Employer bears the risk

These sources of coverage and risk are not mutually exclusive, and health insurance or health benefits coverage for any individual can be some combination of them. **TABLE 2.2** summarizes the sources of coverage and risk.

Sources of Coverage

The sources of coverage refer to where that coverage comes from. This entity may be the company handling the claims but is not always the same. It is also not always clear what that source is depending on which type of payer is providing the coverage. Nevertheless, the easiest way to consider this issue is to look at these three sources:

- Government entitlement programs
- Individual health insurance
- Employer group health benefits plans, also referred to as group health benefits plans (dropping the word "employer")

TABLE 2.2 Sources of Coverage and Risk

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

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

Entitlement Programs

In the United States, approximately 40% of all national health expenditures were paid by the federal and state entitlement programs. Coverage is provided to anyone who is eligible to get it, meaning that person is entitled to that coverage. Government entitlement programs, which may or may not include all or some managed care features, include the following:

- Medicare
- Medicaid
- Uniformed Services through TRICARE* for the:
  - United States Army
  - United States Navy and Marine Corps
  - United States Air Force
  - United States Coast Guard
  - United States Public Health Service Commissioned Corps
  - National Oceanic and Atmospheric Administration Commissioned Officer Corps
- Veterans Administration
- Indian Health Service

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

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

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

plans or other private companies, to administer the program. Those private entities, which are called intermediaries, provide only administrative services, so the government (i.e., taxpayers) remains at risk. In contrast, in private Medicare Advantage and managed Medicaid plans, the risk is transferred from the government to the private plan.

The Federal Employees Health Benefit Program is an employee benefits program for federal employees. Likewise, state and local governments typically provide benefits to their full-time employees. These are not entitlement programs, but rather employer group health benefit plans.

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

Individual Health Insurance

Several different sources of coverage are available to individuals. For example, individuals may purchase health insurance policies directly from commercial insurance companies. In general, individual health insurance policies are more expensive or require more cost sharing than do group health benefits plans.

Under the ACA, as of January 2014 individuals became able to purchase coverage either directly from a health insurer or through a health insurance exchange. Prior to 2014, individuals often needed to first pass "medical underwriting," meaning their health status determined whether they could get coverage. That is no longer the case: Individuals cannot be refused coverage based on health status, at least during open enrollment.

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

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

Individuals may also be eligible for coverage following certain "qualifying events" such as marriage or divorce, losing a job, or child birth or adoption. They must apply for this coverage within 60 days of the qualifying event or they will lose their eligibility. The coverage change may be to their existing benefits plan (e.g., adding a dependent), or to eligibility to obtain coverage.

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

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

(COBRA). COBRA requires employers with 20 or more employees to offer certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. The individual must pay the full cost of that coverage plus 2%, but it is usually less expensive than an individual policy unless the individual qualifies for subsidized coverage under the ACA. Coverage under COBRA is limited to 18 months in most cases, and the end of that period of coverage is considered a qualifying event for purposes of obtaining coverage through the insurance exchange.

Individuals could also obtain coverage under the terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) once their COBRA coverage ran out. This was an important right for individuals who had medical conditions that made it difficult or impossible for them to buy coverage because insurers would not sell to people with preexisting conditions. HIPAA coverage was very costly and the benefits were poor, however. When the ACA made coverage available to all individuals during an open enrollment or following a qualifying event, there was little need for coverage under HIPAA.

Group Health Benefits Plans

Employer-based group health benefits plans are the largest source of health benefits coverage in the United States, accounting for almost half of all coverage. While employers are not compelled to provide coverage, the ACA requires all employers with more than 50 full-time employees to offer qualified health benefits coverage plans or pay a penalty, and it provides tax incentives to encourage small employers to offer coverage. Large employers must automatically enroll new employees into their plan, but an employee can opt out. Even when an employer does offer health insurance, temporary or part-time employees do not have a right to participate in an employer's group health benefits plan.*

Group health benefits plans have several advantages:

- The cost of the coverage is paid on a pretax basis.
- Employers can either purchase group health insurance or self-fund the benefits plan.
- Employers, especially large employers, are usually able to obtain more favorable pricing and coverage than individuals can.
- Large employers often provide employees with different options for type of health plan or amount of cost sharing.
- Healthcare coverage benefits may be combined with other types of benefits (e.g., flexible spending accounts, health payment accounts, or life insurance).
- The employer—not the individual employee—manages administrative needs such as payroll deductions and payment of premiums.

If costs for a group health benefits plan increase, as they usually do each year, the employer generally absorbs much of that cost increase. Employees typically contribute part of their pretax earnings toward the cost of the coverage, usually around 25% of the total cost. As a consequence, as health plan costs rise, the dollar amount of the payroll deduction also rises even though it is the same on a percentage basis. In addition, employers have been steadily increasing the amount of required cost-sharing in their benefits plans in order to keep premiums lower. Because healthcare costs usually rise faster than overall inflation, some of the money an employer might have used for pay raises ends up being used to pay for health benefits, so that higher employee

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

payroll deductions also affect the amount of total take-home pay.

In all cases, however, the cost of the benefits plan paid by the employer as well as the payroll deduction are pretax expenses, meaning they are not considered taxable income to employees. That is not the case for individual health insurance: Individuals must pay their premiums with after-tax dollars, meaning they cannot deduct it from their income taxes (with some exceptions).

Access to Coverage

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

Bearing Risk for Medical Costs

Contrary to popular belief, a health insurance company does not always bear the financial risks associated with the medical costs of its customers or members. In fact, insurers bear the risk in fewer than half of all group benefits plans. Because many day-to-day payer operations are not tied to who is bearing the risk for medical costs, distinctions about who bears the financial risk will be made throughout this text only when this issue is important (as in this section). Here we will briefly look at the most common forms of bearing risk for medical costs.

Government Entitlement Programs

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

Health Insurance

People purchase health insurance to protect themselves from unexpected medical costs. The insurer provides coverage of medical costs and charges premium rates that are calculated to cover those costs on average. A commercial payer can be a for-profit or nonprofit organization.

The central point of health insurance is that the risk for medical expenses belongs to the payer. In other words, in exchange for the payment of insurance premiums, the payer is responsible for paying some or most of the cost of medical care provided to individuals, subject to cost sharing and coverage limitations. Whether the actual costs for a group or an individual are higher or lower than average, the premium payment does not change during the period the insurance policy is in effect.

Federal laws and regulations under the ACA, HIPAA, and Employee Retirement Income Security Act of 1974 (ERISA) apply to health insurance, but, generally speaking, regulation of insurance is the responsibility of the state governments. Because the regulatory system is highly complex, it is only described throughout this text when applicable and specifically in Chapter 8.

Self-Funded Employer Health Benefits Plans

Most large corporations do not actually purchase health insurance to cover their employees. Instead, they fund the benefits plan themselves, a practice called "self-funding." Said another way, in a self-funded plan, the employer is the insurer and the entity that is at risk. Self-funding is mostly used in large groups, although some medium-sized employer groups have also moved to this practice. It is found in large groups

because a risk pool (i.e., a group of covered people) must be large enough to be able to predict costs. In a small group, the impact of chance and luck—good and bad—is higher than in a large group, where experience increasingly outweighs chance as the group gets larger.

Assuming the risk of medical costs makes it possible for a large employer to avoid paying state premium taxes, offering state-mandated benefits, or any other state regulation of benefits. Costs in a self-funded group are based only on the actual costs incurred by the company's employees and their dependents (and in some cases the company's retirees) and are not affected by costs incurred by other groups or individuals. Self-funded plans also do not pay the charge that insurers build into their premiums for the cost of taking on risk and to contribute the insurer's profits or underwriting margins. The cost of bearing risk is real, however, so self-funded employers also purchase reinsurance.

Self-funded benefits plans are not regulated by the states, but they are regulated by the U.S. Department of Labor and to some degree by the U.S. Department of the Treasury. Self-funded plans are also exempt from some, but not all, requirements under the ACA—although as a practical matter, most comply with most of the important requirements. As long as an employer complies with the benefits plan requirements under ERISA and the ACA, there is very little regulation involved.

Self-funded plans may mimic any type of health plan. Employers with self-funded plans typically contract with TPAs, or through ASO contracts with full-service insurers or HMOs. This last type of contract may cause confusion among both members and providers when the benefits and policies of a self-funded plan do not match the payer's insured products. TPAs and ASO contracts are addressed later in the section on Types of Payers.

Association Health Plans

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

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

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

Multiple Employer Plans, aka Taft-Hartley Trusts

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

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

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

Provider Risk

In some forms of provider payment, a contracted provider may assume some portion of risk. The most common arrangement is HMO capitation, in which the provider receives a fixed payment for each member each month regardless of how many or what type of services those members receive from the provider. This type of provider risk is usually limited and does not apply to all medical costs, although some large health systems may take on substantial risk in the form of fixed payments. This is not the same as a provider-owned or sponsored health plan in which a health system also functions as an insurer, which is discussed later in this chapter.

Reinsurance

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

Most states have rules regarding how much reinsurance a self-funded health benefits plan can have before it is considered a commercial group health insurance plan and, therefore, becomes subject to state regulation. For example, if an employer purchases reinsurance to cover expenses that are only 5% higher than what was budgeted for, the state may claim that the employer is insured and not self-funded, which means it must comply with all state laws and regulations for health insurance.

Reinsurance is not the same as health insurance. It comes in many different forms and is regulated differently from health insurance. A reinsurer can apply different rules for defining when something is covered and when it is not. Benefits plans must treat all of their beneficiaries equally and cannot deny ongoing coverage for high cost diseases or people—but a reinsurer can do just that, through "lasering" resulting in the self-funded plan having to continue to pay the benefits costs but having no financial protection from the costs.

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

Types of Payers

Serious challenges are associated with attempting to describe the types of payer organizations in a field as dynamic as health insurance and managed care. The healthcare system has been continually evolving in the United States, and change is the only constant. Nevertheless, distinctions remain between different types of payers.

Originally, HMOs, PPOs, and traditional forms of indemnity health insurance were distinct, mutually exclusive products with different approaches to providing healthcare coverage. Today, an observer might be hard pressed to uncover the differences among these and many newer products without reading the fine print. Further confusing this issue is the existence of provider-based IDSs. Provider-owned or sponsored health plans fall into the broad categories described here, but also have

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

Because of these continual changes, the descriptions of the different types of payer organizations that follow provide only a guideline to the various types of payer organization models or structures. In many cases a payer company may offer multiple products based on many or nearly all types of payer models and called by product names that provide little clue to what type each one's plan type or benefit design.*

Nonprofit, For-Profit, and Member-Owned Payer Organizations

There are three different ways that most payer organizations are structured around ownership and governance. These arrangements are described only briefly here because the types of ownership and governance have no real impact on general operations or marketplace behavior.

In a *nonprofit* plan, the payer is not owned by investors and cannot distribute profits. Such an organization is not really owned by anyone. In one sense, it owns itself, but that does not mean that any board member or employee can claim any ownership rights. Any profits or margins that a nonprofit organization earns belong only to the nonprofit plan. If a nonprofit organization is sold to a for-profit company, or if it converts from nonprofit to for-profit status, that is considered a type of sale. The nonprofit's assets and marketplace value must benefit the community overall, not any private person or group.

In a *for-profit plan*, the company is owned by investors and can distribute profits to its investors. Many of these organizations are publicly traded, meaning their stock is listed on the stock market. Others are owned by either a for-profit or a nonprofit company. Nonprofit companies typically establish for-profit subsidiaries so that the subsidiary's profits can flow back to the parent company.

In a *member-owned plan*, the plan's members own the plan on a collective basis, albeit not in the same way that shareholders own a publicly traded company. Member-owned plans are technically neither nonprofit nor for-profit entities. Three types of member-owned plans exist:

- Mutual insurers, in which policy holders own the company on a mutual (shared) basis.
- Cooperatives (co-ops), which are similar to co-ops found in agriculture or other industries, in which the members of the co-op receive the co-op's services.
- Consumer-Owned and -Operated Plans (CO-OPs), a plan type that was created specifically under the ACA as a means of increasing competition in the health insurance exchanges. CO-OPs share some attributes of co-ops or mutual insurers but have specific requirements that co-ops and mutual insurers do not have. For example, the ACA is very specific about who may and may not be on a CO-OP's board of directors. Most CO-OPs that appeared right after the ACA went into effect failed and are now gone, but, at the time this is being written, four are still operating.

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

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

requirements. As a practical matter, a payer can have any one of these structures and that choice will have no impact on the different types of health plans offered. In other words, all types of payer organizations compete in the same marketplace and are indistinguishable to most people.

The Continuum of Managed Care

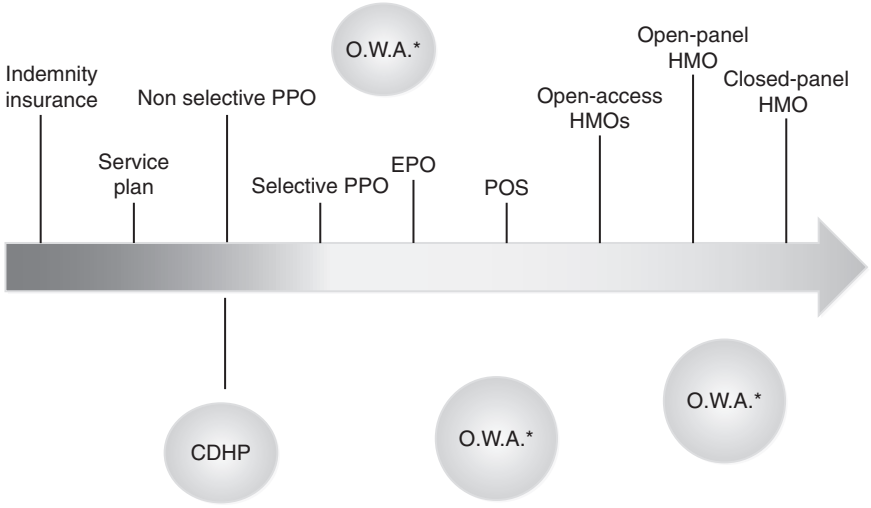
Health insurance and managed care may be thought of as a continuum of models (**FIGURE 2.1**). These models are generally classified as follows:

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

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

- Provider contracts defining terms and requirements
- Tighter elements of control over healthcare benefits
- Addition of new elements of control
- More direct interaction with providers
- Increased overhead cost and complexity
- Greater management of utilization
- A net reduction in rate of the rise of medical costs

Although it would be comforting to classify all payers using the models defined here, payers are anything but uniform and often offer most or all of the various types of plans,



*Other Weird Arrangement; meaning some supposedly clever idea that will solve the cost problems forever but is difficult to administer or understand, and that typically has only a minor impact in the end.

FIGURE 2.1 Continuum of Managed Care

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

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

In the discussion here, various forms of provider payment and medical management approaches will be mentioned when they differ from one type of plan to another, but will not be fully described.

Traditional Health Insurance

Basically, two types of traditional health insurance exist: indemnity insurance and service plans. This type of plan is called traditional because it was the dominant form of coverage in the past—not because it still is. The costs of traditional health insurance rose rapidly beginning in the early to mid-1970s, such that it became very expensive compared to most types of managed care plans. Even with increases in the levels of cost sharing, traditional health insurance remained costlier than the newer types of plans and could not effectively compete in the U.S. marketplace.

The share accounted for by traditional insurance has now shrunk to less than 1% of the total market for healthcare coverage. Most of the traditional insurance companies remain robust, but either changed by adopting managed care, or by exiting health insurance and focusing on other types of insurance.

Indemnity Insurance

Indemnity health insurance protects (indemnifies) the insured (i.e., the policy holder) against financial losses from medical expenses. A person covered under an indemnity plan may receive coverage from any licensed provider. The insurance company may reimburse the subscriber directly for medical expenses, or it may pay the provider directly, although it has no actual obligation other than to pay the subscriber unless required under a state's laws. Payment to physicians and other professional providers is subject to usual, customary, or reasonable fee screens, whereas payment to institutional providers is generally based on charges. There is no contract between the insurer and the providers.

Benefits are generally subject to a deductible and coinsurance. Any charges by the provider that the insurance company does not pay are strictly the responsibility of the subscriber. Most plans usually require precertification of elective hospital admissions and may apply a financial penalty to the subscriber who fails to obtain precertification. Case management may also be used to help control the very high costs of catastrophic cases (e.g., a severely premature infant, a trauma case). Second opinions may be mandatory for certain elective procedures (e.g., surgery for obesity).

Service Plans

Technically speaking, a service plan is not insurance, but rather a form of prepaid healthcare, and it applies primarily, though not exclusively, to Blue Cross and Blue Shield (BCBS) plans. At the time service plans came into being, they were controlled by the physicians and/or hospitals providing the services, but that is no longer the case.

In service plans, relatively few restrictions are placed on licensed providers who sign a contract with the plan. This first appearance of a contract is an important milestone, and an enduring feature of all types of plans except indemnity insurers. A service plan's provider contract typically contains certain key provisions:

- The plan agrees to pay the provider directly, eliminating collection problems with patients.
- The provider agrees to accept the plan's payment schedule as payment in full and not to bill the subscriber for any charges that exceed the amount the plan pays, other than the normal deductible and coinsurance.
- The provider agrees to allow the plan to audit the provider's records related to billed charges.
- Like indemnity insurance, service plans may require precertification, case management, and second opinions.

The principal advantage of a service plan over indemnity insurance lies in the provider contracts and the providers' agreement to accept the service plan's payment terms and not "balance bill" the plan's members for any charges above the amount allowed by the service plan. This also is a feature found in all of the other types of plans except indemnity insurance. It applies only to contracted providers, however; noncontracted providers can and do balance bill patients.

Professional fees allowed under the fee schedule represent a discount to the plan. More importantly, the plan usually obtains discounts at hospitals that indemnity plans do not. The hospitals grant these discounts for a variety of reasons, including large volume of business and timely direct payment. Most service plans have evolved into PPOs, though they commonly maintain the service plan as well. In any case, the organization technically remains a service plan for all but its HMO products.

Preferred Provider Organizations

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

A PPO network contracts with fewer than the total number of providers available in an area. It may be required by law to contract with any willing provider or they may be selective about accepting providers into the network. In the former approach, any provider who wishes to participate in the organization and who meets the conditions and agrees to the terms of the PPO's contract is offered a contract. Selective PPOs, by comparison, apply some objective criteria (e.g., location-based network need, credentials, or practice pattern analysis) before contracting with a provider. Any-willing-provider PPOs are more common, particularly given that numerous state laws require this arrangement, but the use of criteria-based selection still occurs, particularly with expensive or highly specialized services (e.g., for cardiac surgery). It is also used by many insurers that offer "narrow network" products through the health insurance exchanges.

Precertification and case management are almost always components of PPOs, but mandatory second opinion programs are relatively uncommon because they are no longer considered to be effective. Failure to comply with PPOs' rules result in a financial penalty to the provider, not the member. As with service plans, a contracting provider may not bill the member for any balance that the PPO does not pay (other than member cost-sharing), and that includes any payment penalties associated with the provider not complying with precertification.

A hallmark of a PPO is that benefits are reduced if a member seeks nonemergency care from a provider who is not in the PPO network. A common benefits differential is 20% based on allowed charges. For example, if a member sees a network provider, coverage is provided at 80% of allowed charges; if a

member sees a provider who is not in the network, the coverage may be limited to 60% of allowed charges. If the nonparticipating provider charges more than the allowed charges, the member is also responsible for all charges above what is allowed.

Providers agree to discount their services to a PPO because the smaller network combined with the benefits coverage differentials serve to channel patients toward participating providers. Of equal importance, this approach eliminates the risk of losing patients who switch to participating providers. PPOs are less expensive than traditional insurance, but usually more expensive than HMOs. Because they have fewer restrictions and typically contract with larger networks than do HMOs, PPOs have the largest share of the market.

Risk-Bearing PPOs

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

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

Most payers have their own networks, but no payer—other than the federal Medicare program—has a network in place in all parts of the United States. Under the ACA, emergency care must be covered at the in-network level of benefits even for services provided by non-network providers. Mid-size to large employers, however, frequently have employees who live and/or work in locations where a payer may not have a contracted network. In those areas, this potentially means a health plan may have to pay for care delivered based on full charges, and members may not have the protections found in most provider contracts. Self-funded employer groups that use third-party administrators instead of a full-service payer face the same issue because TPAs typically do not have a network of their own.

Blue Cross and Blue Shield plans handle this through their BlueCard program, in which a member of one BCBS plan is able to access another BCBS plan's network providers when away from home. This mechanism is based on an agreement among the Blues plans because those plans are independent, and it provides for seamless access to any Blues network.

Non-BCBS plans must take a different approach for supplementing their own networks, as do self-funded employer groups that use TPAs. The solution in both cases is to contract with one or more rental networks. A rental network comprises a network created either by the providers themselves or by a company that is not affiliated with a single payer. Rental networks are almost always PPO networks, rather than HMO networks (which have more requirements than do PPOs). Any PPO created by providers must not violate antitrust requirements, meaning it cannot act as a means of suppressing competition.

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

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

In decades past, payers did not always make it clear that they had such contracts with rental PPOs, and there was no indicator on the member's identification (ID) card about any rental PPOs. Providers that contracted with

the rental PPO but not directly with a payer would find themselves receiving the PPO payment and not the billed charges, requiring them to write down the difference. This could even happen in an area in which both a payer and a rental PPO had networks, but did not include all the same providers. At the time this was occurring, the arrangement was known as a "stealth" or "silent" PPO. Silent PPOs are now uncommon after several lawsuits were filed challenging this practice, and payers that contract with rental PPOs now typically put the logo(s) of the rental PPO(s) someplace on the member's ID card, usually on the back, though providers do not always look for it.

High-Deductible Health Plans and Consumer-Directed Health Plans

Each year, the Internal Revenue Service determines what the minimum and maximum deductibles need to be to qualify as an HDHP. For 2019, the minimum deductible was $1,350 for individuals and $2,700 for families; the maximum allowable for out-of-pocket costs (meaning deductible plus any other cost-sharing) was $6,750 for individuals and $13,500 for families. In all cases, preventive services are not counted toward the deductible, and the amounts paid toward the deductible are based on in-network costs, not out-of-network costs, just as with any other type of PPO. The maximum deductible amounts for HDHPs are the same as the maximum amount of out-of-pocket spending allowed under the ACA for all insured health plans, and fall within the coverage requirements for a bronze-level plan.

A consumer-directed health plan (CDHP) is an HDHP combined with a pretax savings account. A pretax account set up as part of an employer group health benefits plan is referred to as a health reimbursement account (HRA), and a pretax account applied to individual coverage is referred to as a health savings account (HSA). While they have differences, the overall concept is the same for both types of accounts.*

In a CDHP, qualified healthcare costs (except preventive care) are typically paid first from the pretax account; when that is exhausted, any additional costs up to the deductible are paid out-of-pocket by the member (this gap is sometimes referred to as a bridge or a doughnut hole). The IRS also defines what is considered a qualified medical cost, but it is similar to what would be considered a medical cost in any coverage plan. To be paid from an HRA or HSA, costs must have been incurred while the account existed. A simplistic schematic of a CDHP appears in **FIGURE 2.2**.

Point-of-Service Plans

POS plans combine features of HMOs and traditional insurance plans, but are similar to PPOs in some ways. In a POS plan, members may choose which system to use at the point at which they obtain the service. For example, if a member uses his or her PCP and otherwise complies with the HMO authorization system, minimal cost sharing is required. If the member chooses to self-refer or otherwise not to use the HMO system to receive services, the POS plan still provides benefits coverage but with higher levels of cost sharing, including a higher deductible and coinsurance instead of a copayment.

POS plans are typically based on HMOs, but even then, there are two common forms they can take. The first is a POS plan with two options for cost sharing: (1) minimal cost sharing if the member chooses to stay within the HMO system and (2) significantly higher

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

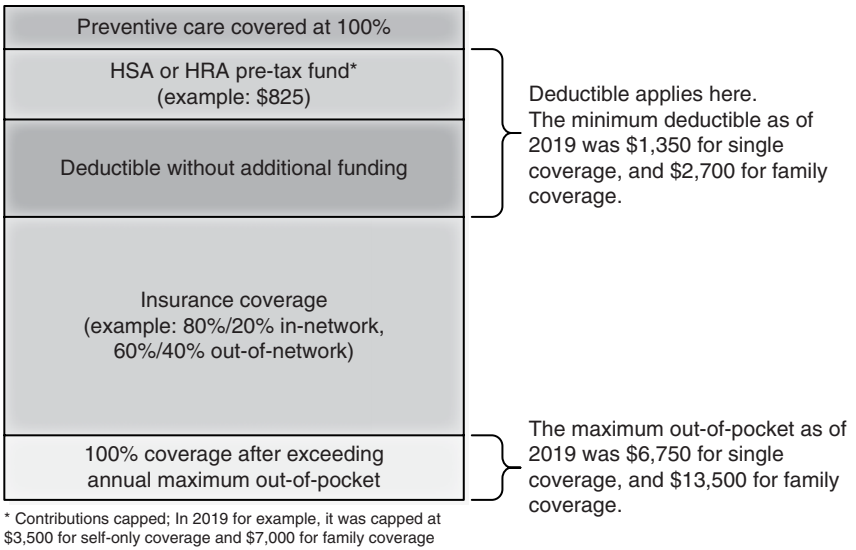


FIGURE 2.2 Example of Basic Construct of a Consumer-Directed Health Plan

levels of cost sharing if the member chooses to go outside the HMO system. The difference between coverage for in-network services and out-of-network services is usually in the range of 30%–40%.

The second type of POS plan is a triple-option plan in which there is minimal cost sharing when the HMO system is used, but there is also an option to use a PPO that is part of the plan. The amount of cost sharing is higher than when the HMO is used, but more closely follows typical PPO benefits design. In other words, cost sharing in this middle tier is less than the amount of cost sharing required for using providers who are not in either the HMO or PPO network. The differences between coverage for HMO in-network services, PPO in-network services, and out-of-network services are usually approximately 20% between the HMO level and the PPO level, and from 40% to 50% between the HMO and out-of-network levels.

While they were initially popular, POS plans have become less common in recent years because their costs are often higher than either PPOs (with more cost sharing) or HMOs (with more controls).

Exclusive Provider Organizations

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

Health Maintenance Organizations

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

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

coverage in an HMO *only* applies when services are provided by the HMO's providers in compliance with the HMO's authorization policies and procedures. Exceptions may be made on occasion when the HMO authorizes benefits for non-network services based on specific medical needs.

The majority of HMOs also manage utilization and quality to a greater degree than do PPOs. In most HMOs, members must access non-emergency care by going through their PCPs. Each member must go first to their PCP for medical care; any other services must then be authorized by their PCP. PCPs are defined as physicians specializing in family medicine, internal medicine, or pediatrics. Women can access their obstetrician/gynecologist (OB/Gyn) directly—direct access to OB/Gyns for women is required under the ACA but was allowed by HMOs prior to the ACA's passage—but most HMOs still require them to choose a PCP. The exception to the use of the PCP as a "gatekeeper" is the so-called "open-access" HMO, which is really a type of EPO that uses an HMO license.

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

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

Open-Panel Traditional HMOs

In an open-panel HMO, private physicians and other professional providers are independent contractors who see HMO members in their own offices or facilities. Physicians in the network typically contract with more than one competing health plan and see non-HMO patients as well. A variety of payment mechanisms may be used in an open-panel HMO. The total number of providers in an open-panel plan is larger than what is found in a closed-panel plan but usually smaller than what is found in a PPO. Members must choose a PCP; they may change PCPs at certain times but only if the new PCP has the capacity to accept new patients.

Open-panel plans fall into two broad categories: IPAs, which are the most common type of HMO, and direct contract models, which are the second most common type. Although the terms IPA and direct contract model are often used synonymously, the two models are distinct.

In an IPA model, an IPA, which is a legal entity, contracts with private physicians (PCPs and specialists) for purposes of then contracting with HMOs or other payers. The HMO in turn contracts with the IPA and pays it a negotiated capitation amount. The IPA may pay the physicians through capitation or use another payment mechanism, such as a fee-for-service scheme. The providers are at risk under this model in that if medical costs exceed the capitation amount, the IPA receives no additional funds from the HMO and must accordingly adjust its payments to the providers. Most IPAs purchase reinsurance to protect themselves financially, and some HMOs provide a similar type of protection from high costs as part

of the overall contract. Finally, the scope of what IPAs do varies, with some IPAs focusing mostly on payment terms and others taking on many routine HMO functions involving medical management and the like.

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

Closed-Panel HMOs

Unlike physicians in an open-panel plan, physicians in a closed-panel plan either are members of a single large medical group or are employed by the HMO. The total number of providers in a closed-panel plan is by far the smallest of any model type. Members usually do not have to choose a single PCP but may see any PCP in the HMO, though they may be asked to choose a primary facility to ensure continuity of care. When specialty care is appropriate, referrals are made to specialists who are also in the HMO to the extent the HMO or group employs specialty physicians. However, even closed panel HMOs also contract with independent specialists to provide care to members who require services that the HMO does not itself provide.

Closed-panel plans fall into two broad categories: group model and staff model. In a group model plan, the HMO contracts with a single medical group to provide services to members. The HMO pays the group a negotiated capitation amount, and the group in turn pays the individual physicians through a combination of salary and risk/reward incentives. The group is responsible for its own governance, and the physicians are either partners in the group or employed by the group as associates. The group is at risk in that if the costs of the group exceed the capitation amount, physician compensation is less—although the HMO generally provides stop-loss reinsurance to the group to protect it from catastrophic cost overruns. Closed-panel HMOs also contract with private physicians to provide services that the HMO's physicians do not provide.

Several types of closed panel HMOs exist. In one type, the HMO and medical group are distinct entities that operate as if they were partners. The largest and best-known example of this type of group model HMO is Kaiser Permanente; the HMO is the Kaiser Foundation Health Plan, and the medical groups are the Permanente Medical Groups (there are different groups for each of Kaiser's regions). In another type of group model HMO, the medical group established the HMO. An example of this type of HMO is the Geisinger Health Plan, a large and successful HMO established by the Geisinger Clinic in Danville, Pennsylvania.

Some medical groups exist primarily on paper and operate strictly as cost pass-through vehicles for the HMO; that is, the costs are simply passed from the medical group to the HMO, and the group does not actually bear any risk for medical expenses. This arrangement resembles a staff model plan.

In a staff model plan, the HMO directly employs its physicians. In some cases, the physicians are employed by a medical group, but it functions like a staff-based organization. Physicians receive a salary, and there is an incentive plan of some sort. The HMO has full responsibility for the management of all activities. Staff model plans run by HMOs are not as common as they once were, but still exist as HMOs created by large integrated healthcare delivery systems (IDS) that have employed physicians.

Network Model HMOs

The term network model is often used to refer to an open-panel plan, but there is (or was) also a related type of network model in which the HMO contracts with several large multispecialty medical groups for services. The groups receive payment under a capitation arrangement, and they in turn pay the physicians under a variety of mechanisms. The groups operate

relatively independently and are best thought of as a variant of the IPA model.*

Mixed-Model HMOs

Nothing in this world is pure and simple, and HMOs—like all types of payer organizations—are no exception. Many HMOs have adopted several model types, even in the same market, to attract as many members as possible and capture additional market share. And even large closed panel HMOs typically contract with independent physicians for some services. Mixed-model HMOs may offer the different models in the same products, or the models may operate independently of each other in different products.

Third Party Administrators and Administrative Services Only Agreements

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

Contracting with Different Companies for Different Services

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

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

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

Contracting with Companies for All or Most Services

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

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

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

Conclusion

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

The means for providing and managing healthcare benefits coverage exists on an ever-evolving landscape of plan types with mutating definitions and operational structures. Even so, the traditional terms such as HMO and PPO retain considerable utility, including stability in the overall aspects of their operations. This characteristic should be looked on not as a hindrance toward understanding but as a mark of the dynamic nature of the industry.

CHAPTER 3

The Provider Network

LEARNING OBJECTIVES

- Understand the basic elements of payer-provider contracts.
- Understand service areas and access standards.
- Understand basic credentialing.
- Understand the basic types of physicians and other healthcare professionals in a typical network.
- Understand the basic types of hospitals, ambulatory centers, and other healthcare facilities in a typical network.
- Understand the basic types of integrated healthcare delivery systems and their relationships between hospitals and physicians, and with payers.
- Understand basic contracting for ancillary services.

Introduction

The backbone of any managed healthcare plan is the provider network, which is made up of contracted physicians and non-physician professionals, facilities, providers of ancillary and therapeutic services, and medical vendors of various types. In many cases, distinctions between provider types that were once clear have blurred over the years as new organizational models have appeared and evolved, leading to differences in how payers contract and interact with them. Even group model health maintenance organizations (HMOs) that provide medical services must contract with a network or independent providers for specialty and facility services the group does not provide.

This chapter explores many different aspects of provider networks. We begin by looking at basic provider contracting concepts and a few important elements common to providers in general, and then examine the most common types of providers and organizational structures:

- Professionals providing health care, with a focus on physicians
- Inpatient facilities, including various types of hospitals as well as multihospital systems
- Ambulatory facilities, such as outpatient surgical centers

- Integrated healthcare delivery systems (IDSs), which combine facilities and professionals from an organizational and contracting standpoint

This chapter does not address provider payment, except in broad terms as needed in the context of the chapter. Provider payment is the subject of its own dedicated chapter due to its complexity and the vast number of payment methodologies currently in use.

Contracts and Contracting

All types of payers other than the (now rare) indemnity plan rely on contracts between the plan and its network of providers. These contracts are legally binding documents that define the terms, conditions, and obligations to which both parties have agreed. In this section we consider why providers and payers might seek a contract in the first place. In addition, we identify some of the key elements found within most contracts, and briefly address contract management.

Payers usually recruit, contract, and maintain their own networks at a local or regional level, but some types of contracting are more centralized. Some payers have outsourced provider recruiting and contracting to another company that specializes in it, but the contracts are still directly with the payer. Some payers or health plans contract with independent rental networks (described in Chapter 2) for their entire network, and some do so to supplement their own networks outside of their normal service areas. For the purposes of this section, we will not distinguish between any of these approaches, but will return to that topic a bit later.

Why Contract?

Contracts between payers and providers are voluntary on both sides, but most providers have contracts with quite a few different payers plus Medicare and (less often) Medicaid. Both payers and providers have their own reasons for wanting to contract with at least some, if not all, health plans in their area. **TABLE 3.1** provides some examples of payer and provider reasons for contracting.

Basic Elements of a Typical Provider Contract

Typical contracts between payers and providers contain page after page of definitions, terms, obligations, and other details of the payer–provider agreement. Terms and clauses that are not expected to change with any frequency are placed in the body of the contract. Terms that are subject to frequent changes, such as actual payment terms and dollar amounts, typically appear in appendices, so that they may be renegotiated or replaced without having to open the rest of the contract to renegotiation.

Some of the contractual terms and language will be the same for all types of providers; other terms and language will apply only to specific types of providers such as professionals or facilities. Some terms may also differ based on the type of product or health plan. This section provides only broad descriptions of common elements, and some of the important but differing elements found in professional and in facility contracts. The focus here is on provider contracts used for the commercial market; those used for Medicare Advantage (MA) and managed Medicaid plans contain a few additional clauses.

Definitions

Definitions are just that—they define terms that are used elsewhere in the contract. Examples of items that are typically defined include the following:

- The type or types of health plan(s) using the contract, such as an HMO or a preferred provider organization (PPO)

TABLE 3.1 Payer and Provider Reasons for Contracting

Examples of Reasons for Payers to Contract with Providers	Examples of Reasons for Providers to Contract with Payers
■ Provide members with access to appropriate medical services and meet access standards required by states and by Medicare	■ Gain business as payers steer members towards contracted providers
■ Obtain favorable pricing, meaning less than full charges*	■ Avoid losing business as payers steer members away from non-contracted (out-of-network) providers
■ Define the types of clinical services the provider will provide to plan members	■ Obtain favorable (higher) pricing when in a strong negotiating position*
■ Define the conditions that determine whether a clinical service will be covered as a benefit and when it is not covered	■ Obtain direct payment and avoid having to get patient to pay, other than defined cost-sharing
■ Obtain contractual agreement for clauses required by state (and federal) laws and regulations, which may differ somewhat for different types of plans	■ Receive payment within a defined time period, usually 30 days or less and often 10 days or less*
■ Define rights and requirements for compliance with plan functions	■ Define rights related to disputing claims and payments

* Payment-related issues are discussed in the Provider Payment chapter but are mentioned here because payment is an important element and motivation for any contract between a payer and a provider.

- The type or types of provider(s) to which the contract applies, such as primary care physicians (PCPs), specialist physicians, hospitals, ambulatory procedure centers, and so forth
- Plan components, such as member, subscriber, medical director, and so forth
- Services that providers are expected to provide under the contract
- Services that providers are not expected to provide under the contract
- Routine, Medically necessary, emergent or urgent, experimental and/or investigational, non-covered and other medical services, some of which may be defined by reference to a plan's evidence of coverage document (described in Chapter 6) or its policy manuals.

Qualifications and Credentials

Participating providers must maintain a defined set of qualifications and credentials as a condition of participation, and the basic requirements are usually included in the main body of the contract. This clause may include some requirements that will not change over time, such as the provider needing to have a current and unrestricted license, as well as language requiring compliance with certification and qualification

and credentialing requirements defined more specifically in an attachment, an appendix, or by reference to a plan policy.

Compliance with Utilization and Quality Management Programs

The contract contains requirements that the provider comply with the payer's utilization management (UM) and quality management (QM) programs, as well as the payer's obligations under these programs. To accommodate periodic changes in these programs, the actual QM and UM programs are typically described in attachments, appendices to the contract, or by reference to plan policies.

Direct and Timely Submission of Claims

The provider agrees to send claims directly to the payer, not to the member. The contract also specifies when claims must be submitted and indicates that claims submitted after that period of time will not be paid. It often requires electronic claims submission as well.

Direct and Timely Payment

The definition of timely payment may be included in the section on payment, or it may be a separate clause. It sets the requirements for how quickly the plan must pay a "clean" claim, meaning a claim that has been processed and not held until more information is submitted and that has not been rejected because the claim form was not correctly filled out. It also requires the payer to pay the provider directly and often also require the provider to agree to payment by electronic remittance.

Hold Harmless and No Balance Billing

The No Balance Billing clause of the contract describes the provider's agreement to accept as payment in full for medical services provided to plan members the amount that the plan determines to be appropriate. It applies to all participating providers in the same manner. For example, if a physician normally charges $100.00 for an office visit but the plan's allowable fee schedule is $75.00, then the physician agrees that under no circumstances will he or she bill the plan member for the $25.00 difference; in other words, the provider will not "balance bill" that difference. The provider may, however, collect or bill the member for the portion that is the clear obligation of the member, such as a copayment, coinsurance, or deductible. Examples of how this works are provided in Chapter 4.

The related but stronger Hold Harmless clause, which prohibits the provider from billing the member even if the plan does not pay the fee at all. The two clauses may both be present or may be combined into a single clause.

All state and federal regulatory agencies require the no balance billing clause for contracts between providers and the plans for almost all forms of network-based managed care plans. The stronger hold harmless clause is an absolute requirement for HMOs and an increasingly common requirement for PPOs and service plans, as well as commercial MA and managed Medicaid plans (see Chapter 7).

Payment

The body of the contract typically contains a short clause describing in general that the plan will pay the provider according to the contract's various requirements, then refers to one or more attachments or appendices for the detailed description of the method or methods of payment. The actual dollar amounts are also usually placed in a separate attachment or appendix because they change from time to time.

Other-Party Liability and Coordination of Benefits

In some cases, more than one payer may be responsible for coverage of medical services.

For example, two working parents may both have coverage through their employers' plans. If the couple's child receives medical care, coordination of benefits (COB) rules determines which parent's plan will be considered the primary payer and which parent's plan will be considered the secondary payer. Similarly, other party liability (OPL) rules, which can vary from state to state, determine when a different type of insurance is designated as primary in terms of the health plan's coverage; for example, an automobile insurance policy may be the primary payer for medical care related to an accident. COB and OPL are addressed in Chapter 6.

Right to Audit

The contract gives the plan the right to conduct audits of medical records and billing data related to care provided to plan members. Audits are typically done for a specific reason, such as a concern about billing problems, but they may also be performed as part of a plan's QM program. QM audits are confined to medical records of members, usually focused on only those seen in PCPs' offices, and often for specified conditions or services, although they may also focus on a provider as part of an investigation of a quality-related concern.

Term and Termination

One section of the contract specifies the period over which the contract remains in effect and the circumstances under which either party may terminate it. Termination provisions have become very complex in many states. In the past, either party could terminate the contract simply by giving adequate notice—90 days' notice, for example. Some states require payers that no longer want a provider's services to furnish the provider with the reason(s) for termination, and a few states have created due process requirements that allow a terminated provider to dispute the termination.

Contracts also usually specify terms under which a contract may be terminated immediately—for example, if the provider's license is suspended or restricted, or if the payer determines that a provider represents an immediate threat to the health of its members. In addition, contracts may provide for provisional participation defining a time period during which some deficiency must be resolved. For example, it takes some time for a newly trained specialist to receive specialty board certification, so the contract may allow that physician to participate as long as board certification is obtained in an appropriate amount of time.

Nondiscrimination

The nondiscrimination clause requires the provider to treat plan members no differently than the provider treats any other patients. In other words, the provider may not discriminate against plan members. This clause also requires non-discrimination in ways similar to how the term is used in civil rights.

Attachments or Appendices

As mentioned, certain contract terms and specifics are subject to periodic change, so they are placed in attachments or appendices to the contract. When changes take place, a new attachment or appendix replaces the old one.

Service Areas, Access Standards, and Network Adequacy

Service areas, access standards, and network adequacy generally refer to the same thing. The service area is a fundamental concept in managed health care. It is defined by state laws and regulations for HMOs, point-of-service plans, and managed Medicaid plans. Some states also have service area requirements for PPOs, although not all have followed this path. Federal laws and regulations define service areas for MA plans and Qualified Health Plans (QHPs)

selling through the exchange. Both federal and state regulations apply to managed Medicaid plans; if a state's requirements are more stringent, then the state requirements apply. Like all laws and regulations, access standards are revised or even redefined from time to time.

A service area is simply the defined geographic area in which an HMO or any type of payer that must comply with access requirements, provides access to primary and specialty care, hospital care, emergency care, and certain other health services. If the payer cannot provide sufficient access to providers in a geographic area, it will not be allowed to sell its services in that area.

Unlike HMOs, health insurers typically are licensed to sell their products and services anywhere throughout the state in which they are licensed, and that permission often applies to their PPO products as well. Some states, however, require PPOs to meet access requirements for a defined service area, though they may be more loosely defined than HMO standards. Most large employers have access requirements as well, though they may differ for a local HMO versus a regional or national PPO.

Service area network access standards—also called network adequacy standards—are usually defined by county, ZIP code, or travel time or distance by type of provider. In some cases, the standards are defined by appointment availability. Minimum access requirements for professional providers usually differ for PCPs, specialists, and behavioral healthcare providers, in recognition of the reality that it is reasonable to travel a little farther to see a specialist. HMO access requirements for PCPs count only PCPs with open practices, meaning those that are accepting new patients. Distance requirements for rural areas usually allow for fewer providers per geographic area or for greater travel time. **TABLE 3.2** provides a simplified generic example of service area access requirements.*

Network adequacy or access standards can be complex as well. For example, Medicare uses formulas to calculate the minimum number of hospitals and physicians that an MA plan must have under contract, by specialty, based on five overall locale designations that have 13 different sub-designations. While not common, a few states define access standards according to how long it takes to get an appointment; such requirements apply only to managed care plans, not the providers, and do not consider how long it takes to get an appointment regardless of the type of coverage.

Payers usually use automation to monitor access. Even so, one of the biggest challenges payers face is keeping their provider directory current. This relates to access standards in two ways: keeping current as to which providers are in the network and which no longer are (for any reason), and which network providers are no longer accepting new patients. Regulators are aware of this challenge and have begun placing more pressure on payers to maintain current and accurate directories, including performing spot-checks.

Many health plans participating in the health insurance exchanges created under the Affordable Care Act (ACA) created products that used networks that were narrower, or smaller, than the networks used by their non-exchange products, while still meeting regulatory access requirements. The plans did this to better manage costs under the presumption that new members who obtained coverage through the exchanges would include many people who were sicker than average. However, it was initially difficult for consumers to figure out exactly which providers were in these networks and whether they were even accepting new patients. As a result, the Center for Medicare and Medicaid Services (CMS) issued new access standards for QHPs selling through the exchange.

* Generic examples are just that and should not be relied upon in place of applicable state and/or federal access requirements for any plan.

TABLE 3.2 Generic Example of Service Area Access Standards

Type of Provider	Type of Locale	Example of Access Standard
PCPs	Urban	Two PCPs within 3 miles of each ZIP code
	Rural	Two PCPs within 30 miles of each ZIP code
Specialty Physicians (may vary by specialty)	Urban	Two of each major specialty within 30 miles of each ZIP code
	Rural	Each major specialty within 100 miles of each ZIP code
Acute Care Hospitals	Urban	Within 30 minutes of each ZIP code
	Rural	Within 30 miles of each ZIP code
Specialty Care Hospitals	Urban	Within 1 hour of each ZIP code
	Rural	Within 3 hours of each ZIP code

Physicians and Other Professionals

Physicians constitute the largest part of a payer's network. The typical health plan network also includes many other types of clinical professionals, including those for which no access standards apply. For purposes of this chapter, such providers include many different types of licensed professional healthcare providers who hold a valid and unrestricted license in the state in which they practice, who practice independently (meaning not under the supervision of a physician), who bill for their services separately from any facility, and who meet the plan's credentialing requirements. **TABLE 3.3** provides examples of some types of non-physician professional healthcare providers with whom a payer may contract, though not all payers contract with all these types of providers. Some of these will be discussed further in this section.

Non-physician licensed professionals who are employed by a facility or by a physician and work under supervision are typically not considered to be network providers—for example, physician assistants (PAs), nurses who staff a hospital, pharmacists employed by a pharmacy, and laboratory technicians. These employed professionals do not bill directly for their services, although the facility or physician may include their services as part of any overall charges. Payers do not contract with these types of professionals, and credentialing is the responsibility of the facility or physician employing them.

Primary Care and Specialty Care Physicians

Most managed care organizations divide the physician network into PCPs and specialty care physicians (specialists), but such distinctions are not always clear. Even in the absence of a health plan design that requires members to access

TABLE 3.3 Examples of Non-Physician Professional Healthcare Providers with Whom a Payer May Contract

Clinical nurse practitioners (CNPs)	Home healthcare providers	CNP Midwives
Psychologists	Podiatrists	Audiologists
Clinical social workers	Physical therapists	Respiratory therapists
Licensed professional counselors	Chiropractors	Optometrists
Certified alcohol and drug abuse counselors	Dentists, orthodontists and oral surgeons	Nutritionists
Psychiatric nurse practitioners or nurse psychotherapists	Occupational therapists	Acupuncturists
Marital and family therapists	Other rehabilitation therapists	Soothsayers & alchemists*

* Not really.

their PCP to obtain either direct care or referral authorization for specialty care (i.e., gatekeeper HMOs), a great deal of the regular health care of Americans is delivered by PCPs. Plans that do require members to designate a primary provider are required under the ACA to allow any available network PCP, or Gynecologist for female members, to be so designated, assuming that PCP has the capacity to accept new patients.

Physicians specializing in family practice, internal medicine, and pediatrics are considered PCPs. General practitioners (GPs)—meaning licensed physicians who have not completed residency training—on rare occasions may also be considered PCPs in rural or underserved areas with a serious shortage of board-certified PCPs. However, the number of GPs has steadily decreased, and commercial health plans rarely contract with them anymore.

For many years now, the number of graduating physicians who choose to become PCPs has been steeply declining as PCPs' income has lagged the incomes of almost all other specialties. This has resulted in a national shortage of PCPs, which is worsening each year. Non-physician providers such as CNPs and PAs can and do provide primary care and thereby improve access, yet significant problems in accessing primary care persist in many parts of the United States.

While some PCPs specialize only in general primary care, many internists are also board certified in a subspecialty—for example, pulmonary medicine or gastroenterology (pediatricians and family practitioners may have additional training as well, but subspecialties are far more common in internal medicine). Unless such a specialist restricts her or his practice to only specialized conditions or procedures (e.g., a gastroenterologist who sees mostly patients referred by other physicians), it is common to have a practice mix consisting of both specialty care and primary care patients. For that reason, and because of increasing shortages of PCPs without subspecialties, most HMOs and POS plans allow internists to classify themselves as both a PCP and a specialty care physician.

For traditional HMOs and POS plans, the distinction between PCP designation and SCP designation is important because of how specialty services are authorized and paid for. In the

past, some HMOs did not allow an internal medicine specialist to be both a PCP and a specialist for the same member to avoid double-visits as a PCP authorizing another visit to the physician as a specialist. That is still be done by some HMOs, but it is at least as common now for HMOs to differentiate coverage, payment and cost-sharing amounts based on the reason for the visit. In other words, using computerized algorithms during claims processing to internally designate a physician as a PCP for some patient visits, but a specialist for other types of visits and specialty-related procedures.

Hospital-Based Physicians

Hospital-based physicians (HBPs) occupy a unique position, and for that reason it is worth describing them separately. In this discussion, the term HBP refers only to those physicians who practice in hospitals and/or ambulatory facilities, and do not provide office-based care. For purposes of this chapter, HBPs also do not include physicians who are employed by a hospital but have otherwise typical patient care practices, even if their office(s) are physically located within the hospital facility. For example, it does not include a cardiologist whose community-based private practice was acquired by a hospital, or a PCP who is employed by the hospital and sees patients at a hospital-owned annex or office building.

HBPs are typically classified into one of five specialties:

- Radiologists
- Anesthesiologists
- Pathologists
- Physicians practicing full-time emergency medicine*
- Full-time hospitalists*

The first three groups of specialists—those in radiology, anesthesiology, and pathology (sometimes referred to as RAPs)—are traditional types of HBPs who have been associated with hospitals and ambulatory facilities for more than a half a century. These physicians must be board certified in their respective specialties. They frequently practice in a single medical group, which is typically the only group providing those services to the hospital (although exceptions exist). RAP HBPs are always associated with a facility or facilities and typically do not provide traditional office-based care, though radiologists specializing in radiation treatments for cancer may do so.

Emergency departments (EDs), also referred to as emergency rooms (ERs), have been staffed by specialists in emergency medicine for many decades. ED physicians also may be part of a medical group with exclusive rights, or they may be employed directly by the hospital. Emergency medicine is a recognized specialty, and most, but not all, ED physicians are board certified as such. Some EDs also include physicians in other specialties such as internal medicine or general surgery on their staffs, but the care they deliver still falls into the category of emergency medicine.

Hospitalists are physicians who concentrate solely on the day-to-day management of inpatient care. In some cases, the hospitalist may concentrate solely on critical care, in which case he or she is also referred to as an intensivist. Most of these physicians are board certified in internal medicine, although other types of specialists may also become hospitalists. Until recently, there was no specific board certification for the hospitalist specialty, but that situation is now changing. For example, the American Board of Internal Medicine has developed a Focused Practice in Hospital Medicine pilot program that is intended to lead to an internal medicine specialty board.

In most cases, neither a patient nor a payer has the option to select an HBP. Moreover, because of their exclusivity, HBPs may resist contracting with a payer from which

* Full-time emergency department physicians and hospitalists may be board certified in various other specialties but are included here because payers generally face the same issues with all five types of HBPs.

they have been accustomed to getting their full charges, since contracting may not bring them increased business. Payers, in contrast, are often reluctant to contract with hospitals or facilities if the HBPs do not also sign a contract, because the plan and its members will then be exposed to the HBPs' higher charges and balance billing, often called "surprise billing."

Hospitals argue that except for their employed physicians, who may include hospitalists and sometimes ED physicians, traditional HBPs are independent physicians and not under the control of the hospital. While that is true for non-employed HBPs, the hospital is the only party with enough leverage to bring the HBPs to the negotiating table: By definition, the hospital is the only place where the HBPs practice, for all practical purposes, although some large HBP groups may serve more than one hospital system.

If a hospital is not critical to include in the payer's network, a refusal by HBPs to contract with a payer may result in the payer refusing to contract with the hospital or refusing to agree to terms that the hospital wants. This negotiating tactic often proves effective because hospital executives and other physicians on staff at the hospital may be effective in persuading HBPs to agree to contract.

Conversely, if a hospital has no near competitors or is so important that it must be included in the network, the hospital may choose not to make the effort, or at least not for any payer with which it does relatively little business, because it knows it will get the business even without participation by its HBPs.

HBPs may also provide services in outpatient settings such as diagnostic imaging facilities and ambulatory surgery centers (ASCs). As these typically focus on elective procedures or diagnostic studies, a payer would probably not contract with an ambulatory or diagnostic center unless the HBPs associated with the center also contracted with the plan.

Finally, there are medical groups or companies with physicians who are board certified in emergency medicine and who have privileges at multiple hospitals that contract with payers to take responsibility for members seen in the ED and held for observation or possible admission. These participating network physicians are often able to manage such cases in a cost-effective manner, decreasing the potential for an avoidable admission.

Telehealth or Telemedicine Physicians

This category refers to physicians who "see" patients via secure audiovisual connections. They often work for a company or facility that provides this form of urgent care for relatively simple problems such as minor illnesses such as a skin infection, a flare-up of a chronic condition, or for follow up visits. The physician can see the patient on video, including requesting a close-up view of something, and can then provide advice or call in a prescription. In most states, physicians who practice telemedicine must be licensed in the same state as that from which the patient is at the time of the telemedicine visit. They must also meet the payer's credentialing standards discussed later in the chapter.

Payers contract with telemedicine organizations to provide a form of convenient access to care for minor conditions, but at a lower cost than an emergency room. They do not function as PCPs or for ongoing care, though some physicians are beginning to add this capability to their regular practice.

Physicians Other Than Medical Doctors and Doctors of Osteopathy

A few types of physicians other than MDs and Doctors of Osteopathy (DOs) may be in a payer's network. Unlike MDs and DOs, who are licensed to practice medicine and surgery without limitations (although MDs and DOs rarely try to practice beyond the scope of their

training), these other types of physicians are licensed to practice only within the scope of their specialty. Contracting and credentialing are generally similar to what is used for MDs and DOs, though it may be somewhat less extensive.

Payers typically contract with podiatrists (DPMs) who are licensed to provide care and perform surgery for conditions related to the foot and ankle. Podiatrists are also licensed to prescribe any or most types of drugs.

Chiropractors (DCs) are not licensed to prescribe drugs or perform surgery, do not have admitting privileges to hospitals or ambulatory surgical facilities, and typically focus on issues of the spine. In some states, payers are required by law to recognize chiropractors as being in the same category as MDs and DOs for purposes of contracting and designation in the directory.

Payers that do not provide dental benefits typically do not contract with dentists or orthodontists, but this practice varies widely. Plans typically do contract with oral surgeons though, for oral surgery related to medical conditions and trauma.

Non-Physician or Mid-Level Practitioners

Non-physician clinicians (NPCs) or mid-level practitioners include PAs and certified registered nurse practitioners (referred to as CRNPs, CNPs, or NPs). In addition to NPs practicing primary care, several other types of NP designations exist, each having a different focus and training—for example, advanced practice registered nurses, nurse–midwives (RNMs or NMs), nurse anesthetists (CRNAs or NAs), and clinical nurse specialists (CRNSs or CNSs).

Licensure and regulation of PAs is similar from state to state, with PAs needing to practice under physician supervision. Physician supervision refers to a physician being responsible for the clinical care provided by the PA, but not necessarily directly observing their practice behavior. Approximately one-third of all PAs practice in hospitals, another third practice with medical groups, and the remaining third are found in a variety of situations. All states allow PAs to write prescriptions, though some limitations may apply.

In contrast to the approach taken with PAs, states vary considerably in how they license and regulate NPs. Some states allow NPs to practice independently, without physician involvement, for defined types of services and procedures. More states require some form of physician involvement with an NP's practice. All states allow NPs to write prescriptions but vary in the types of prescriptions that may be written and the degree of physician oversight that is required.

As noted earlier, payers typically only credential and contract with NPCs who practice independently and bill for their services directly. NPCs employed by or associated with facilities and/or medical practices are not typically credentialed or contracted with separately from the facility or medical practice, and any bills for their services are part of the facility's or group's bill. In the case of retail clinics such as those found in some national drug store chains or as a free-standing facility, the NPC is employed by the facility or company and therefore does not have a direct contract with any payer, but the company employing the NPC typically credentials them in a manner that meets most payer's credentialing requirements.

Behavioral Health and Substance Abuse Therapists

Table 3.3 listed some, but not all, types of professionals who provide behavioral health and substance abuse services. Many practice independently and may be under a direct contract with a payer, while others provide services as employees of an organization or facility that signs the contract with the health plan.

A therapist may provide all types of therapy, but it is much more common for a professional to focus on either behavioral health/mental health or substance abuse therapy. Only psychiatrists, who are either MDs or DOs, may prescribe drugs or admit patients to a hospital.

Other Professionals

Other types of professionals, many of which were listed in Table 3.3, also may be found in a health plan's network, though their inclusion varies from plan to plan and from state to state. For purposes of this chapter, all further discussion about the professional network will address only the physician network.

Credentialing

Prior to signing a contract, a provider must meet the payer's credentialing standards. Credentialing provides limited—but important—information about a physician's training, current certifications and licensure, locations, and so forth. Credentialing is performed by obtaining copies of documents from a physician, verifying that some documents represent the current state (such as having an active and unrestricted state license to practice), and having the physician provide other information as required. Specific examples are provided later in this section.

An important aspect of credentialing is the potential to uncover adverse actions levied against a physician, such as an excessive number of malpractice lawsuits, a licensure suspension or limitation, loss of hospital privileges, and other reportable actions described later in the section. Malpractice lawsuits and even some sanctions are not necessarily, by themselves, indicators of a quality problem, though. In U.S. society it is almost impossible to practice medicine without being named in a suit, especially in high-risk specialties like obstetrics or neurosurgery; and some sanctions may not reflect any medical quality or risk problems.

Each state has regulatory credentialing requirements that HMOs, and sometimes PPOs as well, must meet to do business in the state. State credentialing requirements may vary from state to state, though not by much. The federal government also has regulatory credentialing requirements applicable to MA and managed Medicaid plans. The federal credentialing requirements are generally similar to those for commercial plans but have some specific differences such as participating in Medicare (or Medicaid as appropriate). State and federal credentialing requirements represent a base level, and payers may use more than what is required under regulations.

Credentialing requirements for HMOs were once more extensive than they were for other types of payers such as PPOs, but an increasing number of payers now use the same requirements for all of their products, even if not required to do so by the state. Many state regulators, as well as the payer industry overall, generally follow the credentialing standards developed by accreditation organizations such as the National Committee for Quality Assurance (NCQA) or URAC;* their credentialing standards are briefly discussed here, while accreditation overall is discussed in Chapter 5.

The responsibility for credentialing typically resides with either a medical director, a physician chair of the credentialing committee, or a vice president overseeing networks. Regardless of where the responsibility lies, the requirements are generally the same. Plans usually also establish a credentialing committee that reviews applications and credentials and determines if a provider meets the requirements for initial credentialing or recredentialing. Payers, like hospitals and other provider organizations, typically maintain internal

* In the past, URAC stood for Utilization Review Accreditation Commission, but the organization's name has since been officially changed to URAC alone.

documentation of its credentialing policies and procedures. Payers also typically credential those non-physician professionals with whom the payer contracts directly, as described earlier.

Some applications are held for further review while additional information is obtained, and in a few cases a provider will be denied a contract because of not meeting credentialing requirements. In cases in which a provider is terminated from the network, or in the event a provider appeals the denial of a contract, the credentialing committee reviews the case. Credentialing is usually considered part of the plan's QM program, and the deliberations of the credentialing committee—which is made up of physicians—are therefore considered a form of physician peer review that is confidential and not subject to disclosure.

The initial credentialing process is carried out prior to contracting with a new physician, prior to adding new physicians in a group or facility already under contract, or, rarely, after an interim contract or letter of intent is signed. Initial credentialing of a physician is more extensive than recredentialing, which typically takes place every 3 years following initial credentialing.

Documentation Typically Used in Physician Credentialing

Most, but not all, credentialing materials are relatively standard for physicians, and comply with the credentialing standards set by the accreditation organizations. Credentialing information such as demographics or identifiers may be provided via a credentialing form, either on paper and submitted by mail or fax, or entered through a secure online portal. In many cases, at least for initial credentialing, copies or images of documents must be provided, such as a copy of the license to practice medicine, a copy of the medical diploma, a copy of the face sheet of the malpractice insurance policy showing coverage effective dates, and so on. Some or all credentialing information may be self-reported by physicians, but it may also be obtained through a repository maintained by a third-party organization, which reduces the administrative burden on the providers.

TABLE 3.4 provides a few examples of the types of physician credentialing information and/or documents that are commonly required. For purposes of recredentialing, providers must update this information as necessary. Note that the examples in Table 3.4 are only simplified descriptions of a partial list of the many types of information used in credentialing by payers.

In the past, HMOs were required to also conduct at least an initial on-site office evaluation for PCPs and high-volume specialists, but it is no longer required.

Verification

Many credentials must be independently verified, which is also called primary source verification; it means confirming each document with its primary source. Examples of credentialing documentation that usually requires primary source verification include:

- Contacting each states' board of medicine (for physicians) in which a physician has a current active and unrestricted license to practice medicine
- Contacting a physician's medical school to verify that he or she received an MD or DO
- Contacting a physician's malpractice insurance carrier to verify that coverage is adequate and in-force

Payers may perform verification themselves, but more often it is delegated to an accredited credentials verification organization (CVO); accreditation in this case meaning the CVO meets the verification standards set by accreditation organizations such as NCQA and URAC. CVOs also serve as repositories of common credentialing information. This reduces the administrative burden on providers and payers alike. One of the most widely used accredited CVO and credentialing

TABLE 3.4 Examples of Some Basic Types of Required Physician Credentialing Information and Documentation

Demographics such as name, birth date, location, and so forth	Hospital privileges
Medical license number and expiration date for each state in which the physician has an active license.	Ambulatory surgical center privileges
Drug Enforcement Agency number and expiration date, state prescribing number and expiration date if a state requires it	Professional liability insurance
National Provider Identifier (NPI—see Chapter 6), tax ID, and other applicable legal or regulatory identifiers	History of malpractice awards and settlements
Education and training dates, locations, and degrees or certifications earned	History of professional sanctions and other adverse events
Specialty board certification(s) and expiration date(s)	Work history and references
Practice details	Billing and remittance information
Participation status with Medicare and Medicaid programs	Disclosure questions

repositories is the nonprofit organization CAQH.* It is not used by every payer, but it is used by a substantial number of them, including most of the major commercial payers and Blue Cross Blue Shield plans.

Health Care Quality Improvement Act of 1986 and The Data Bank

One specific type of query and verification used in both initial credentialing and recredentialing, is the Data Bank, a federal database created by combining two other federal databases—the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

The NPDB was created by the Health Care Quality Improvement Act of 1986 (HCQIA) and became operational in 1989. The HCQIA also provided for qualified immunity from antitrust lawsuits for credentialing activities as well as professional medical staff sanctions when the terms of the act are followed. To be eligible, such entities must both provide healthcare services and have a formal peer review process for the purpose of furthering the quality of health care. Information reported to the NPDB is considered confidential and may not be disclosed except as specified in the regulations.

The HIPDB was created under HIPAA as a means of combatting fraud and abuse in health care and health insurance. It holds healthcare fraud and abuse data based on

* CAQH was once an acronym, but it is now the name of the organization.

required reporting and disclosure of certain final adverse actions (excluding settlements in which no findings of liability were made) taken against healthcare providers, suppliers, or practitioners that are not related to actions or events that are reported to the NPDB. In 2013, the HIPDB was joined to the NPDB, and now called The Data Bank.

The Data Bank—that is, the combined database—holds data about malpractice awards and settlements, actions against privileges, actions limiting the scope of a provider's practice, sanctions, and healthcare fraud and abuse findings for physicians and non-physician providers.

By law, all covered entities, including hospitals, state medical boards, malpractice insurers, payers with provider networks, and others, must report any of these actions as well as some other information. Only hospitals are required to query the Data Bank, but many other covered entities, including payers, are allowed to do so. Several other entities are required to report but prohibited from querying. The general public is not allowed to query it.

The Data Bank is the gold standard source of information about such events, and payers routinely query it for initial credentialing and with each recredentialing. Not all sanctions and disciplinary actions merit action on the part of the plan, but either a pattern of sanctions or disciplinary actions or an egregious problem, including deliberately deceiving the plan regarding such actions, usually results in the plan terminating that physician's contract.

Types of Physician Contracting Situations

Physicians contract with payers through several different types of organizations, ranging from contracting as individuals to contracting through entirely different types of providers such as IDSs. In this section, we look at a few of the common types of contracting situations involving physicians.

Individual Physicians

One common type of physician contracting situation is the direct contract, in which a physician contracts directly with the health plan and not through any third party or intermediary. This traditional arrangement was once the most common type of contract but is declining as more physicians become employees of hospitals, medical groups, and other types of organizations. The major advantage of this approach is that it creates a direct relationship between the plan and the physician, which makes it cleaner and simpler to interact. The major disadvantage is that the relationship is with only one physician, such that the effort required to establish and maintain that relationship is disproportionately greater than when physicians are part of a larger organization.

Traditional Medical Groups

Traditional medical groups are legal entities, often taking the form of a professional corporation (PC) or a partnership. With this model, the physicians share office space and support services such as scheduling and billing, and jointly (though not always equally) share costs and profits. Groups have been growing steadily as fewer physicians go into solo practice. In some parts of the country, medical groups remain relatively uncommon, while in other areas, groups are the dominant form of practice.

Small groups (i.e., 2–10 physicians) usually operate relatively cohesively, but in some cases the physicians in the group are more like individual physicians sharing support staff and billing. Medical groups can be single-specialty practices (e.g., all primary care internists or all orthopedic surgeons) or multispecialty practices.

Larger groups usually include both partners and employed physicians. The physicians who are partners jointly own the group and share in the costs and profits of the business, and physicians who are employed by the group have no ownership interest and are paid a salary with incentive bonuses. Over time, some employed physicians will be offered partnerships within the group. When both types of physicians make up a group, only the partners have the authority to sign a contract, but all physicians in the group must meet the payer's credentialing standards.

Most plans will refuse to contract with a group unless all the physicians in the group agree to abide by the contract. Many payers—and HMOs in particular—also will not contract with a group unless all its physicians meet the payer's credentialing criteria. They impose these requirements because if some physicians in the group are not in the network or do not meet credentialing criteria, then members who see participating providers in that group may potentially receive care from nonparticipating and/or non-credentialed providers who are covering on-call cases, seeing urgent call-in cases, or covering for a physician who is away.

Captive Medical Group

Organizations such as hospitals or specialty management companies that employ physicians sometimes do so through a captive medical group. This is common in states with Corporate Practice of Medicine (CPM) laws that prohibit a corporation (other than a PC) from practicing medicine or employing a physician to provide professional medical services; though a few states with CPM laws allow certain corporations such as hospitals or HMOs to employ physicians.

Contracting with captive medical groups goes through the entity with which the captive group is associated, such as a hospital. Even then, however, the contract is with the captive group, though it is typically negotiated in combination with the facility contract. This specific topic is also discussed later in the section on multihospital health systems (MHSs).

Group Practice Without Walls

Another type of medical group, known as a group practice without walls (GPWW), is usually made up of formerly independent physicians who have pooled their resources and now contract as a single medical group, and jointly (though not always equally) share costs and profits. However, the physicians in a GPWW continue to practice in separate offices and do not interact as frequently as physicians within a traditional medical group. A GPWW may also be a captive medical group if it is used by hospitals as an umbrella for those physician practices it has acquired in the community, so it is included in the section on IDSs.

Independent Practice Associations

An IPA is a legal entity that contracts with independent physicians, with the IPA then contracting with health plans. Most IPAs encompass all or most specialties, including primary care, but some single-specialty IPAs exist. The most common type of HMO is the independent practice association (IPA) model plan.

For the payer, the primary value of contracting with an IPA is that it brings a large number of physicians into the health plan at one time. Only one negotiation is required because all of the IPA physicians agree to abide by the terms settled between the IPA and the payer. The IPA may also be willing and able to accept more financial risk than a solo physician or small group could. In addition, some IPAs carry out delegated functions such as network management, credentialing, and even medical management (both UM and QM) on behalf of the payer. However, the limits the ACA placed on the percentages of premium that may be

used for administrative functions and profits (see Chapter 6) extend to delegated administrative functions as well, requiring payers and IPAs to track those reportable costs.

Contracting with IPAs has two primary disadvantages. First, an IPA can function somewhat as a union, with the IPA holding a considerable portion (or perhaps all) of the delivery system hostage during its negotiations—a fact not lost on the U.S. Department of Justice. IPAs that function as anticompetitive forces may encounter difficulties with the law. Second, the plan's ability to select and deselect individual physicians is somewhat more limited when contracting through an IPA than when contracting directly with the providers. However, all physicians in the IPA must still meet credentialing standards.

Physician Practice Management Companies

A physician practice management company (PPMC) may employ physicians or may manage a medical group, including negotiating with payers. Some PPMCs are focused on specialized care, while others focus on groups of community physicians. Payers contract with the PPMC, with the managed medical group, or with both.

Management Services Organizations

In its simplest form, a Management Services Organization (MSO) operates as a service bureau, providing basic practice support services to physicians. These services include such activities as billing and collection, administrative support, and electronic data interchange. The MSO should, through economies of scale as well as good management, be able to provide those services at a reasonable rate.

MSOs can be owned and managed in a variety of ways; for example:

- An MSO may be owned by the MSO's physicians themselves and managed either directly or by another company under contract.
- An MSO may be owned and managed by an independent company, may also purchase independent physicians' practice assets (but not necessarily the practices), and contract with those physicians on a long-term basis.
- An MSO may be owned by a hospital and managed either by the hospital or by another company under contract.

Independent physicians contract with the MSO, but usually have no obligation to practice exclusively under the MSO unless the MSO has purchased the physician's practice, or the physicians are employed by the MSO.

Some MSOs go beyond practice management and incorporate functions such as QM, UM, provider relations, and member services. In some cases, MSOs with these extended functions also contract with HMOs to accept global risk and are able to both manage utilization and negotiate favorable pricing from hospitals and referral specialists.

Foundations

A foundation is a nonprofit organization that contracts for services with physicians and medical groups and may even contract with hospitals. Foundations date back to the early days of HMOs, when community physicians used the foundation to hold the HMO license in order to compete with existing group model HMOs. But foundations are still used in some states with CPM laws as a vehicle for a nonprofit organization such as an HMO or hospital to purchase physician practices. Because foundations are organized as nonprofit, they must usually be able to demonstrate a substantial community benefit. More common in the past than today, foundations of this sort are now mostly confined to a few states.

Hospitals and Ambulatory Facilities

In the past, recruiting hospitals into a new plan's network was a primary area of focus. In today's market, payers usually only add new hospitals to their networks when they expand their service areas. At present, the focus is mainly on network maintenance and periodic renegotiation of existing contracts. But it is not the only focus, because of the need to renegotiate contracts due to continual hospital mergers and acquisitions. Also, ambulatory facilities have grown in both number and scope.

The approach taken toward hospital and facility network development and maintenance is affected to some degree by the type of payer. An HMO is more likely to have a smaller network than a PPO, for example. In past decades, HMOs often contracted with a limited number of hospitals to obtain significant discounts in return for channeling patients to those facilities, but that dynamic eroded in the face of market demand for broad networks. As costs have escalated, however, interest in narrower networks has resurfaced, particularly for products sold through the health insurance exchanges.

Types of Facilities with which Payers May Contract

A payer typically has many different types of facilities in its contracted network. Hospitals may be for-profit or nonprofit, owned either by investors or the community. Hospitals also vary in their focus, including general acute care, tertiary care, or single specialty. Ambulatory facilities are even more widely varied. They include, for example, ASCs, and facilities focused on specific types of procedures such as endoscopy centers, dialysis centers, urgent care centers, and so forth. They may be owned by a health system, by the physicians who use the facility, or by a for-profit company; alternatively, they may be jointly owned by different types of parties.

Community-Based Single Acute Care Hospitals

Once the dominant type of hospital, the numbers of community-based single acute care hospitals (i.e., nonprofit hospitals that are not part of a larger MHS) have been in a slow decline in the United States for decades. Though they can be found in most parts of the country, they are now seen most often in rural areas. However, many have closed for economic reasons, and others are being acquired by expanding MHSs.

Contracting with rural free-standing acute care community hospitals can be difficult if there are no viable alternatives. They are also far less likely to negotiate payment terms beyond the most basic forms. Fortunately, at least some rural hospitals are also lower cost inpatient facilities, as they have fewer high-tech services and located in low-cost areas. A payer may agree to a minimal discount to obtain agreement on the rest of the contract's terms, if a particular hospital is necessary to have in its service area. Single independent hospitals surrounded by larger competitors are usually receptive to contracting as a response to competitive pressures.

Multihospital Systems

Consolidation in the U.S. hospital industry has been significant. From the mid-1990s through today, the total number of hospitals has slowly decreased. More striking is the move from independent hospitals to MHSs through acquisitions and mergers, though MHSs have also built some new facilities. According to the American Hospital Association, as of 2016 about two-thirds of all community hospitals in the United States were in MHSs;* and while

* https://www.aha.org/system/files/2018-05/2018-chartbook-table-2-1.pdf, accessed June 6, 2018.

the pace has slowed a bit due to antitrust concerns, consolidation continues.

Hospital consolidation has had a profound impact on the hospital networks of health plans. As hospitals have merged into regional MHSs, thereby eliminating competition, they have wielded significant market power to negotiate substantial increases in annual payment rates. Large MHSs also typically require that all hospitals and ambulatory facilities in their system be included in all products a payer sells as a condition of contracting with the system's flagship hospitals.

As described in Chapter 1, and will be addressed again later in this chapter, MHSs also now employ large numbers of PCPs and high-volume specialists, either directly or through a captive medical group. This has provided even greater negotiating leverage for MHSs as well as leading to increases in physician fees and in the use of the MHSs' owned services.

In the past, large systems sometimes exerted their negotiating leverage by insisting on exclusivity in the geographic area they served, leaving smaller and less competitive hospitals out in the cold. Antitrust concerns have diminished this practice to some extent, or the MHS has acquired its competitors.

Nonprofit vs. For-Profit Hospitals

According to data from the American Hospital Association that was cited above, as of 2017 just under 60% of all community hospitals in the United States were nonprofit, while for-profit hospitals accounted for about 20%; the rest were Federal, Psychiatric, Long Term Care, or Institutional. MHSs can be for-profit or nonprofit, though nonprofits are more common on a local or regional basis.

For-profit hospitals range from free-standing individual facilities owned or leased by the physicians who use them, which are discussed separately, to national hospital corporations that own and operate facilities in multiple locations that may not all near each other. Some were built as new facilities, while others are nonprofit hospitals that were acquired by for-profit hospital companies. In a few locations, for-profit hospital companies have achieved the type of market dominance attained by nonprofit MHSs.

What matters to payers is how much dominance an MHS has in a community, and, as a practical matter, payers see only a few differences between negotiating and contracting between for-profit and nonprofit hospitals and MHSs. The biggest difference is that a free-standing nonprofit community hospital or MHS has complete autonomy to negotiate, while hospitals in national MHS or for-profit chains are more centralized. Beyond that, negotiating terms such as payment amounts and facilities to be included in the contract are a function of local and/or regional concentration that is associated with market power, and status as a for-profit or nonprofit has no impact.

Specialized Hospitals

Some hospitals specialize in providing care to only certain types of patients. They can be classified into two broad categories: hospitals that provide care for patients with serious complex conditions, and hospitals that provide specific types of procedures and care for patients with less intense and/or chronic conditions.

Children's hospitals are an example of hospitals that focus on providing care to children with complex conditions. Women's hospitals, focusing on conditions specific to women, and obstetrics in particular, are less common than they once were, but are otherwise similar, as are other types of specialized facilities such as eye and ear hospitals. Examples of hospitals providing less intense or chronic care include rehabilitation hospitals and hospitals providing psychiatric care or substance abuse treatment, as well as many physician-owned single-specialty hospitals discussed later.

Hospitals specializing in very complex care usually have few, if any, competitors that can provide the same degree of specialized care. As a result, health plans will usually be able to

obtain a contract, but payment terms are typically high. Hospitals providing chronic or long-term care are much more likely to agree to favorable rates if they also admit patients with Medicare and Medicaid, but are less likely to negotiate if they serve only private-pay patients.

Government Hospitals

Some hospitals may be controlled by local and state governments or by the federal government. County-run community hospitals differ little from any other nonprofit acute care hospital. State-run hospitals sometimes focus on specialized care, such as long-term psychiatric care, although many of those facilities have closed over the years.

Hospitals run by the federal government include those managed by the Department of Veterans Affairs, the Department of Defense, the U.S. Public Health Service, and the Indian Health Service. In the past, they usually did not contract with commercial payers because they did not depend on those sources for revenue. Some do contract however, in order to facilitate billing payers when beneficiaries have dual coverage.

Subacute Care: Skilled or Intermediate Nursing Facilities

In addition to contracting with acute care hospitals, payers usually contract with at least one subacute facility (i.e., a skilled or intermediate nursing facility) and/or rehabilitation facility within the service area. Subacute facilities are well suited for prolonged convalescence or recovery cases (e.g., a patient requiring prolonged traction, a frail patient requiring prolonged intravenous antibiotics for a deeply seated infection, or a patient requiring prolonged stroke rehabilitation), if home therapy is not appropriate for some reason, because the cost for a bed-day in a subacute facility is much less than the corresponding cost in an acute care hospital. In other cases, a patient may be able to be cared for at home, but it is still more cost-effective to deliver the therapy in the subacute facility due to more favorable pricing achievable through economies of scale.

Hospice

Hospice is a broad term referring to healthcare services provided at the end of life. Such services may be delivered within an inpatient facility, an ambulatory facility, or a program that has no facilities of its own. In most cases, the contract between a payer and the hospice organization will be similar to the contracts that apply to subacute care facilities or home care.

Ambulatory Surgical Centers and Other Ambulatory Facilities

In the context of payer network contracting and management, ambulatory facilities refers to the various types of facilities in which physicians and others do procedures or provide specialized services on an outpatient basis. It does not refer to the offices in which physicians and other professionals see patients in the normal course of practice. The cost of a physician's office is built into the professional payment, while facilities bill separately from any professional charges, but many MHSs add separate facility charges when patients are seen by the physicians they employ without reducing the charge for the office visit.

There are different types of ownership of ambulatory facilities; examples include:

- Hospital-owned, including MHS-owned
- Independent free-standing facilities owned by private companies
- Physician-owned
- Payer-owned
- Joint ventures between any of the above parties

There is usually greater competition between ambulatory facilities than between hospitals. Health systems, particularly MHSs, typically require a payer to contract with their ambulatory facilities as a condition of

contracting overall. A demand to exclude competing ambulatory facilities may be seen as anticompetitive, however, so payers often contract with multiple facilities. This approach allows payers to obtain more favorable pricing, which is important because simply changing the site of care from an inpatient setting to an outpatient setting does not necessarily reduce costs.

Facilities in which outpatient surgery and other invasive procedures are performed are often referred to as ASCs, and some use that term for any type ambulatory facility. The number of ASCs has been increasing over the years, as have the number of procedures performed in ambulatory facilities overall. Similar to single-specialty hospitals, these facilities are typically equipped to handle only routine cases, though many can accommodate patients who require general anesthesia.

ASCs are not the only types of ambulatory facilities; many are nonsurgical. **TABLE 3.5** provides some examples of common types of ambulatory facilities.

Credentialing of Hospitals and Ambulatory Facilities

Hospital and facility credentialing refers to facilities meeting applicable state licensure and accreditation standards, as well as participation with Medicare and Medicaid. Payers do not credential facilities the same way that they credential physicians and other professionals for several reasons, the most important of which is that payers simply do not have the resident knowledge to adequately assess the many types of facilities in a community. Conversely, state licensure agencies and facility accreditation organizations do have the necessary expertise, knowledge, and experience to properly evaluate facility performance against industry standards.

Likewise, payers do not typically contract with or credential the non-physician professionals who work at facilities—for example, nurses, pharmacists, CRNAs, PAs, technicians (e.g., radiology, lab, pharmacy), and so forth.

TABLE 3.5 Examples of Some Common Types of Ambulatory Facilities

General ambulatory surgical centers	Birthing centers
Single-specialty ambulatory surgical centers	Infusion centers for chemotherapy, specialty drug infusion, and the like
Observation centers	Diagnostic imaging centers
Endoscopy centers	Community health centers (not including offices of primary care providers)
Lithotripsy centers	Hospice
Surgical recovery centers	Burn and wound management centers
Radiation oncology centers	Urgent care centers
Pain management centers	Retail health clinics or convenient care clinics
Women's health centers	Occupational health centers

The facility is responsible for that task, and state requirements as well as the standards of the facility accreditation organizations include those criteria.

States typically carry out the inspections and initial evaluations of new facilities, after which they accept accreditation by recognized facility accreditation organizations as meeting state and industry standards and requirements. Hospital accreditation is usually carried out by The Joint Commission,* though there are also other acceptable accreditation organizations. For community hospitals, this is usually sufficient and no further credentialing is done.

Ambulatory facilities are credentialed in similar fashion, though the accreditation agency may be an organization other than the Joint Commission. For example, the Accreditation Association for Ambulatory Health Care (AAAHC) focuses on ambulatory facilities such as ASCs, endoscopy centers, dialysis centers, and many others.

Examples of acceptable accreditation organizations other than the Joint Commission and AAAHC include the following:

- Healthcare Facilities Accreditation Program, focusing on osteopathic hospitals
- Det Norske Veritas, focusing on hospitals
- American Association for Accreditation of Ambulatory Surgery Facilities focusing on ASCs
- Community Health Accreditation Program (CHAP), focusing on community services such as home health, hospice, and similar programs
- Accreditation Commission for Health Care, focusing on community services similar to those accredited by CHAP

In some cases, a health plan will establish further criteria that are applicable to certain types of care—for example, cardiac surgery or bariatric surgery (for morbid obesity). Examples of such criteria might include:

- A minimum number of cardiac bypass operations each year
- A percentage of patients who achieve the defined outcomes following obesity surgery
- A staffing ratio of nurses and physicians for an intensive care unit
- Participation in National Cancer Institute protocol studies

A hospital that meets the appropriate criteria for a defined set of procedures would be considered a center of excellence, and the health plan would, at a minimum, selectively refer those types of cases to the hospital and provide higher levels of coverage. In some cases, especially with HMOs, the plan may provide benefits coverage only when a center of excellence is used for certain procedures.

Physician Self-Referral

Physician self-referral is a term that means a physician owns or has a financial interest in a facility and/or ancillary service that the physician uses or orders. Physician self-referral is not confined to ownership or to a direct relationship to the physician. It also includes a facility or ancillary services provider in which the physician, or an immediate family member, has a financial relationship such as ownership, leasing, investment, or financial compensation. It does not typically apply to owning common stock in a large health corporation or having a financial interest in a facility or provider that the physician does not refer to or use.

Self-referral represents a unique and significant problem in health insurance and managed health care because compelling evidence shows that physicians who have a financial interest in a facility or an ancillary services provider will use it far more often than will physicians without an ownership interest.

* Formerly called the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Ambulatory Facilities and Services

Physicians typically have devices that they use in the normal course of practice; for example, internists often have an electrocardiogram machine, and obstetrician/gynecologists usually have an ultrasound machine, and neither would be considered self-referral. But some physicians also have far more costly devices such as a magnetic resonance imaging machine or a cardiac nuclear stress test, that are usually required to be in a separate facility. On average, physicians with a financial interest in a costly device use it much more often than those that do not; sometimes up to three times more often.

From a contracting perspective, it is neither practical nor desirable to completely restrict physicians' ability to perform procedures, or to use appropriate services or equipment that they own or lease and use to deliver routine care within their specialty. For example, orthopedists cannot properly care for their patients if they cannot take X-rays in their offices and obstetricians must be able to perform ultrasounds.

But it is too costly to ignore this potential conflict of interest completely. Payers, therefore, use different contracting and payment approaches, and UM to try and reduce its impact. It is not always easy to identify, however, so payers may do pattern analysis on utilization of costly services to identify it, which is addressed further in Chapter 5. Under the ACA, physicians who use or refer their patients to facilities in which they have a financial interest must now inform the patient of that relationship.

Physician-Owned Single-Specialty Hospitals and Ambulatory Facilities

Physician-owned hospitals account for slightly fewer than 10% of all hospitals in the United States, and are found in most, but not all, states. The physicians who use the facility may own the entire hospital, or they may have an ownership or equity interest that is shared with non-physician owners such as a management company. They are typically focused on a type of specialty that is associated with a high volume of procedures, such as interventional cardiology (catheterizations, pacemakers, and so forth), orthopedics, eye surgery, and so forth.

Physician-owned hospitals typically do not have EDs and are not equipped to handle patients with multiple and/or significant medical conditions. As a result, they are often criticized by leaders of community and teaching hospitals, who accuse them of "skimming" off the most lucrative cases, meaning they admit only healthy patients who require fewer resources for their care and who also have private insurance and/or Medicare coverage. In addition, studies show the same strong relationship between physician ownership and high utilization rates that was seen for ambulatory facilities and costly devices.

The Medicare Modernization Act of 2003 froze the ability of physicians to self-refer to new single-specialty hospitals in which they had an ownership interest (existing ones were not included), but that restriction expired in August 2006 and development of new hospitals resumed. The ACA, however, limited expansions of the number of operating rooms, procedure rooms, and beds in physician-owned facilities, and prevented any facilities that were not certified as Medicare participants by December 31, 2010, from billing Medicare. The ACA also now requires physician-owned hospitals and the physician-owners to disclose an ownership interest to patients.

Commercial payers differ widely in their approach to negotiating with physician-owned single-specialty hospitals. Some avoid these facilities because of concerns about overutilization. Other payers choose to contract with them because of they offer prices significantly lower than the typical general hospital and are often willing to accept capitation from HMOs

(see Chapter 4). When a payer does contract with a single-specialty hospital, the general and tertiary hospitals in the network may seek an increase in their own payments, because presumably those patients not treated at the single-specialty hospital will be sicker and require more resources for their care.

Conversely, some of these facilities elect not to contract with private payers. The physician-owners still direct cases to their hospital. This means that their patients will have higher cost-sharing requirements for using a non-network hospital, but the physician-owners might offer to waive the difference, so the patient no longer has a financial incentive to go elsewhere. Because the hospital's charges are so high, they still profit.

Integrated Delivery Systems

An IDS, sometimes called an integrated healthcare delivery system or integrated system, may comprise any of several provider organizational structures involving different types of providers. By common usage, an IDS has at least hospitals and physicians, though other types of providers are commonly involved too.

To be considered a true IDS, it must have some type of legal structure for purposes of managing health care and billing or contracting with payers, even with a health plan that the IDS owns and operates. To avoid violating anti-trust laws, a true IDS must also have some amount of combined clinical responsibility and aligned or comingled financial incentives. IPAs meet most of these requirements and are essentially physician-only IDSs but are not usually considered IDSs unless part of an IDS that includes one or more hospitals.

Considerable overlap exists between different types of IDSs, and, unlike what we saw when defining types of payers, there are few hard definitions applicable to only one type. IDSs also change and evolve over relatively short periods of time. Even the use of the term "integrated delivery system," IDS, or the like is no longer as common as it once was. It is more common to use the term health system, which confusingly may refer to either an MHS, and/or a true integrated health system. In any case, the terminology used here for different types of IDSs is more to understand how they may look and operate than for applying accurate labels.

Independent and Hospital-Employed Physicians

Because the core of an IDS are its hospital(s) and physicians, we will first look at two main types of hospital-physician relationships: physicians who are employed by the hospital and independent physicians. We will then look at common types of IDSs in the context of its relationships with physicians.

Hospital-Employed Physicians

For our purposes, we are considering only physicians employed full-time by a hospital. Physicians come to be employed by hospitals from many directions. In some cases, the hospital purchased their practice. In some cases, a physician simply leaves a practice in favor of hospital employment. Some physicians have relocated, and hospital employment allows them to begin quickly and without the cost of establishing a practice. Finally, physicians may be recruited right out of their training or fellowship programs.

Recall from Chapter 1 that in the 1990s, hospitals acquired PCP practices as a response to the growth of managed health care. In most, but not all, cases, such moves were followed by serious financial losses, as physician productivity plummeted. Many hospitals then divested their physician service lines, sending the PCPs back out into their own practices.

Within a decade, hospitals once again began to employ physicians, both PCPs and specialists, and that trend accelerated so that by 2015 more than 140,000 physicians were employed by hospitals. About one third of all practicing physicians in the United States are now employed by hospitals, though that percentage has leveled off for now. There are now few, if any, large or mid-sized communities that are not dominated by large MHSs with substantial numbers of employed physicians. And an MHS with many employed physicians is a de facto IDS.

It is important to understand that for a physician to be considered as hospital-employed, a direct employer-employee relationship between the health system and physicians is not necessary or even common. It may be more common for the physicians to be employed by a captive medical group that is owned, controlled, or otherwise exclusively affiliated with the MHS.

As noted already, when a hospital employs a sufficiently large number of PCPs and specialists, it substantially increases its negotiating leverage, particularly as payers face increasing state and federal access requirements. This increased negotiating leverage means the MHSs with large numbers of employed physicians are able to regularly obtain higher prices from commercial payers.

There is potential value to payers in IDSs/MHSs with many employed physicians as well:

- The employed-physician type of IDS helps meet a payer's access needs for PCPs and specialists
- Such a system may have more efficient practice management, including greater electronic data exchange
- The IDS is able to invest in and effectively use electronic medical records and other electronic capabilities
- Working with payers on new models of care and new payment structures is encouraged in the ACA
- The IDS can work with payers to create smaller "private label" network products

In response, a few large payers have begun to acquire provider practices too. Though not to the same degree as hospital systems, the numbers can still be large. As of the time of publication for example, UnitedHealthcare, one of the largest national payer companies, employed about 30,000 physicians around the country, owns nearly 250 urgent-care clinics, and approximately 200 ambulatory surgical centers. All of this primarily through acquisitions.

Independent Physicians

In the context of this chapter, independent physicians include any practicing physicians who are not employed by a hospital. That includes not only solo practitioners, which is in decline, but also being in a medical group as an employee or a partner, or even being employed by a payer. Payer-employed physicians are usually not a part of hospital-controlled IDSs, but medical groups often are.

IDSs involving mostly independent physicians may face federal scrutiny for potential antitrust violations such as price fixing. That risk is lower if physician payment involves some level of financial risk sharing as discussed in Chapter 4, and/or the IDS includes substantial clinical integration as discussed in Chapter 5.

IDSs that include independent physicians also may not be able to use a single contract or signature page with a payer; that is, a separate contract or signature page may be required for each independent provider. Also, many states will not allow health plans (especially HMOs) to enter into contracts with any entity that does not have the power to bind the provider. In most cases, this issue is addressed by having a master contract between the IDS and the payer that contains the terms and conditions; the contracts between the payer and each independent provider are then relatively short and serve to legally bind the provider to the terms and conditions in the master contract.

Hospital-Employed and Independent Physicians in IDSs

The two types of physician relationships are not mutually exclusive in an IDS, and it is common to see both in the same system. Nevertheless, the dynamics are different in each of these models. Some types of IDSs involve mostly or only independent physicians, and a few involve mostly or only employed physicians. Most, however, support both types of relationships between hospitals and physicians. When an IDS includes substantial numbers of employed and independent physicians, tension may arise if the independent physicians come to believe that the IDS favors its employed physicians.

Common Types of IDSs

As noted already, there are few, if any, pure form types of IDSs, and quite a bit of blurring between these different models. **TABLE 3.6** lists some common types of IDSs, mostly for purposes of understanding certain important elements. Those that were not already introduced will be described in this section.

Physician-Hospital Organizations

PHOs are organizations that, at a minimum, allow a hospital and at least some of its independent physicians to negotiate with payers. PHOs are considered the easiest type of integrated system to develop, although managing them successfully is anything but easy.

PHOs may do little more than provide a negotiating vehicle, although this can potentially create an antitrust risk if the arrangement gives the appearance of being used to fix prices. The weakest form of PHO is the messenger model. With this approach, the PHO analyzes the terms and conditions offered by a payer and transmits its analysis results and the contract to each physician, who then decides on an individual basis whether to participate. More commonly, the PHO has a limited amount of time to negotiate the contract successfully—90 days, for example. If that deadline expires without agreement on a contract, then the participating physicians are free to contract directly with the payer; if the PHO successfully reaches an agreement with the payer, then the physicians agree to be bound by those terms.

PHOs also may actively manage the relationship between payers and the PHOs physician participants, or they may provide other administrative services. The "PO" portion of a PHO need not always be individual physicians, but rather might be an entirely different model; for example, a GPWW or an IPA (though not both) could represent the physician portion of the PHO. There is little reason to use a PHO with employed physicians, regardless of how the MHS employs them.

In the mid-1990s, PHOs were formed primarily as a defensive mechanism to deal with an increase in managed care contracting activity. Even then, it was not uncommon for the same physicians who joined the PHO to be under contract with one or more managed care plans. Since then, fewer PHOs have been created, and while existing ones continue to operate, the popularity of this type of IDS has greatly declined.

Management Services Organizations

MSOs operating without a hospital component were addressed earlier. The defining element of MSOs is that they also provide services to physicians, but they may also provide a vehicle for negotiating with payers.

MSOs were described earlier but are mentioned here because MSOs may be a component of an IDS. Some hospitals and MHSs use MSOs with at least some of their independent physicians with admitting privileges. MHSs

TABLE 3.6 Common Types of Integrated Delivery Systems

Type of IDS	Relationship to Independent and Employed Physicians
Physician-hospital organization (PHO)	Used almost exclusively with independent physicians. The physicians may participate as individuals, medical groups, GPWWs, or some combination. Physicians may also participate solely through an IPA. PHOs are not always true IDSs, though they can be.
Management services organization (MSO)	MSOs are used primarily with independent physicians but may be used when physicians are indirectly employed or otherwise exclusive to the IDS. An MSO can also be combined with a GPWW or an IPA.
Foundation, GPWW, and captive medical groups	GPWWs are used primarily for physicians employed indirectly due to state laws prohibiting the employment of physicians by non-physicians. It is also used to more easily bill for services by employed physicians, separate from other services. A GPWW may also be used for physicians employed by an entity other than a hospital. All of these models may be combined with an MSO.
Patient-centered medical home (PCMH)	Originally conceived as geared toward independent physicians, it can apply now to both independent and employed physicians, including both at the same time. PCMH is listed here because they are a type of IDS, but are addressed in Chapter 5, not here.
Accountable care organization (ACO)	Can apply to both independent and employed physicians, including both at the same time, and will mirror the distribution of independent and employed physicians who provide care at the hospital system. Some IDSs may choose to focus their ACO primarily on their employed physicians, however.
MHS with many employed physicians in multiple specialties	This is a truly integrated delivery system and has already been described, so will not be described further here.
Vertically integrated system	A term that, if used at all, usually refers to an IDS that also offers a health plan. The system may own and operate the plan itself or it may be a partnership or joint venture with an existing payer.

may also use MSOs with their employed physicians. When the MSO is owned and operated by a hospital, the MSO must be paid by the physicians at fair market value for its services, or the hospital and physicians could incur legal problems. The same concept applies if an MHS-owned MSO is used to acquire a physician's practice.

Foundations, Group Practice Without Walls, and Captive Medical Groups

These have all been described earlier and are only noted here because they may be a significant component of an IDS, defining the relationship between the hospital system and its physicians. All three may be used for IDSs with independent physicians or employed physicians, though GPWWs and captive medical groups are more likely to be used when physicians are employed by the MHS.

Accountable Care Organizations

Accountable care organization is a term coined by the Medicare Payment Advisory Commission, adopted by CMS, and incorporated into the ACA. For Medicare, it describes an organized group of providers that coordinates the care for designated beneficiaries in the traditional Medicare FFS program. An ACO typically is focused on patients with significant chronic conditions and high costs. ACOs are used in the traditional FFS Medicare program, and also found in the commercial sector, but not in the same configurations. Accreditation organizations (Chapter 5) have developed standards for ACOs that accommodate both Medicare ACOs and commercial ACOs. ACOs are usually paid through some form of Value-Based Payment (VBP), including a methodology used by CMS in the traditional FFS Medicare program, which is described further in Chapter 4.

ACOs in FFS Medicare

ACOs in the traditional FFS Medicare program were described in Chapter 1, and content found in that chapter will not be repeated here. But there are a few additional elements to add. As used in FFS Medicare, ACOs are a narrowly defined organizational structure under federal law, though if one really looks at them, they are as much a structure to support a particular payment methodology (described in Chapter 4) as anything else.

Many different types of provider organizations may be eligible for designation as ACOs, although some restrictions apply. An ACO can be structured as an IDS working mostly with independent physicians, its employed physicians, or both; or it could be structured as a physician-owned entity that may or may not include hospitals. All of the provider members in a Medicare ACO must demonstrate meaningful commitment by either contributing financially, providing services, and being subject to the ACO performance standards. In addition, CMS requires ACOs to meet other standards in governance, management, and so forth. An ACO must have at least 5000 traditional Medicare beneficiaries assigned to it by CMS, but nothing requires beneficiaries in the traditional Medicare program to use an ACO for care. These topics are linked to payment, so further discussion is deferred to Chapter 4.

To test the ACO concept, CMS had begun an ACO pilot program prior to passage of the ACA. That pilot program was still under way when the ACA was passed, but the new law included language requiring CMS to press ahead with ACOs even though it was not clear if they would achieve their goals. As described in Chapter 1, about one third of existing Medicare ACOs have earned a shared savings bonus, but it is still unknown how well the ACO concept will work on a long-term basis, and CMS is constantly modifying the program.

ACOs and Commercial Payers

As defined in the ACA, CMS contracts with Medicare ACOs only for the traditional FFS Medicare program, and does so in a relatively uniform way. Commercial payers may also contract or even partner with ACOs, but in the commercial sector there is no consistency between different payers or with CMS regarding definitions, organizational structures, payment methods, or much else relative to ACOs, other than a general focus on members with

significant chronic illnesses, but even that is not consistent and some ACOs focus on an entire population of members. The main difference between most agreements between payers and ACOs and those between payers and IDSs is a component of VBP, but not like what is used by Medicare. Commercial payers have also reported improved costs or outcomes after contracting with ACOs, but they do not always include the full costs associated with running the ACO, including enhanced medical management. Like Medicare ACOs, it remains unknown as to how well commercial ACOs will work as time goes on. In both cases however, there is reason for hope.

Vertical Integration

Vertical integration refers to a concept once thought to be the future of the healthcare sector in the United States: physicians, hospitals, and health insurers all part of a single entity. The thinking was that by bringing these elements under the same umbrella, incentives would be aligned, and efficiencies would prevail. Many IDSs attempted to vertically integrate in the 1990s and early 2000s. While some succeeded, many ended in failure and loss. In most cases, failure of vertical integration did not result in failure of the health system though, only of the strategy and vertical structure.

The reasons for failure were operational, organizational, and strategic. Specifics of some of these potential problems are discussed in Chapter 6, and the reader is referred to that chapter for more specific information. Here it is enough to know two things: First, because most of the revenues to the hospitals and physicians came from other sources rather than the vertically integrated system, financial incentives did not change much; and second, provider-owned health plans attract sicker people, which is called adverse selection.

Not all failed, of course. Large and well-managed medical groups were often able to succeed, as did some strong regional MHSs that approached the payer aspect with as much seriousness as existing successful payers. Unfortunately, this tack also often resulted in strained relations with the independent physicians, at least initially.

The environment has evolved in the past few decades, and more recently some IDSs and payers have tried partnering to create narrow-network products in which the IDS has more responsibility and shares more in the financial performance of the organization. Some IDSs have returned to the strategy of creating their own licensed health plans, though some contracted or partnered with an existing commercial payer to provide sales and administrative services. It is not possible here to predict the overall success or failure of any of the new vertically integrated approaches, other than to note that at least a few vertically integrated MHSs that started plans since the mid to late 2000s have since shed them.

Ancillary Services

Ancillary services are physician-ordered medical services that are provided on an outpatient basis, and that often do not require direct physician supervision. Some diagnostic services companies sell directly to consumers and do not require a physician order, such as a free-standing genetic or cardiac testing company, but testing performed without a physician's order is seldom, if ever, covered by health plans.

Common Types of Covered Ancillary Services

Most covered ancillary services may be broadly divided into diagnostic and therapeutic. Examples of diagnostic ancillary services include such things as:

- Laboratory
- Specialized laboratory such as genetic testing

- Imaging, such as routine radiology (X-rays), nuclear imaging, computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), and the like
- Electrocardiography ambulatory cardiac monitoring and the like
- Any other types of outpatient diagnostic testing services

Examples of therapeutic ancillary services include such things as:

- Home care
- Generalized rehabilitation and habilitation
- Focused rehabilitation such as cardiac or post-stroke rehabilitation
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech therapy
- Suppliers of vendors of durable medical equipment and medical supplies
- Any other types of outpatient therapeutic services

Pharmacy services are a special form of ancillary services that account for a significant portion of overall healthcare costs and are discussed in Chapters 4 and 5. Medical transportation is its own category but is not addressed in this book. Custodial care is also a form of ancillary service but is not covered by any benefits plan other than Medicaid for those who qualify, and it too is not addressed further.

Contracting for Ancillary Services

Ancillary services are often provided by independent companies. Hospitals also provide non-urgent outpatient ancillary services, but typically have higher prices than do free-standing ancillary services providers. Ancillary care provided as part of an inpatient stay or an outpatient procedure is included in the overall facility services and is not traditionally counted as ancillary services for purposes of separate contracting.

Because ancillary services are elective and non-urgent, payers commonly contract with a limited number of ancillary providers, often through a national or regional chain. This is not always the case however, and payers that are able to obtain favorable pricing from multiple providers on a non-exclusive basis by contract with many of them to provide more convenience to members. Payers may limit what physicians may bill for ancillary services, but not all do so.

Payers generally rely far more heavily on favorable pricing terms to manage the cost of ancillary services than they do on managing utilization, though they may apply UM (see Chapter 5) to certain high-cost services if utilization is higher than expected. As with facilities, payers rely on state licensure and, in some cases, external accreditation or certification for credentialing.

Network Maintenance

Network maintenance is an important function for any payer, and particularly for HMOs. Recruiting and credentialing new providers is an ongoing activity, but more focus is typically placed on maintenance of the existing network. Maintenance includes activities such as recredentialing, resolving claims or other problems, managing access to providers, managing network issues that affect members' experiences, and managing the overall relationship between the providers and the payer. Many plans differentiate between network management for facilities and network management for the professionals because the network for professionals changes more often, which is the source for the access challenges noted earlier in the chapter.

How plans approach network maintenance is continually changing. For example, the increase in self-service capabilities via the web allows provider staff to handle many routine tasks such as checking eligibility, submitting authorizations, checking on claims status, and reconciling submitted and paid claims.

For issues not addressed through self-service, most routine network maintenance relies on the provider's office staff. But physicians themselves should not be neglected, and regular two-way communication with network providers is important, as are communications channels that provide for physicians to directly contact a plan medical director. In addition, bringing network physicians into projects, and paying them fair market value for their professional time and effort, is both beneficial and helps the plan achieve its goals.

Conclusion

One of the hallmarks of managed health care is the existence of a provider network, and this applies now to nearly every form of health insurance and benefits plan as well. Payers depend on their networks to deliver medical care to their members; even closed-panel HMOs depend to some degree on a network of private physicians and hospitals. A payer's network is an asset and a critical part of its overall ability to succeed over the long term.

CHAPTER 4

Provider Payment

LEARNING OBJECTIVES

- Understand the difference between payment and reimbursement.
- Be familiar with standardized electronic transaction code sets used for provider billing and payment.
- Identify the basic elements of risk-based and non-risk-based provider payment.
- Describe the most common forms, modifiers, and variations of provider payment for:
  - Physician services
  - Hospitals
  - Ambulatory medical facilities
  - Pharmaceuticals
  - Ancillary services
- Describe the common forms of payment that combine hospital and physician payment.
- Identify the basics of value-based payment (VBP) and pay for performance (P4P) used by payers in the private sector.

Introduction

The reason for broadly referring to private health insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other types of health benefits plan administrators as payers is because that is what they do: Administer payment for covered medical goods and services. Of course, payment is not the only thing they do, but it is a core function. Coverage determinations and payment is also how they manage utilization; not by denying care, but by not paying for medical care or goods that do not meet the health plan's requirements for coverage.

It is obvious that payers do not pay—now or perhaps ever—all types of providers in the same way. What is not so obvious is the astonishing number of different ways in which such payments are made, along with the continual introduction of new and increasingly complex approaches to payment. Payment models have also been blurring and blending for decades, and they continue to do so. In short, payers, consultants, and policy makers seem to be endlessly creative in terms of how to pay providers and how they attempt to use payment methodologies

to change provider behavior in ways that will lower costs, or at least slow the rate of increase in those costs, and to improve performance.

But provider payment is not magic, and no payment model alone will be able to solve the problem of health cost inflation. Nevertheless, certain methods of provider payment are less likely to cause cost inflation, and that alone is a worthy goal. More importantly, payment can be a tool in which the financial incentives of providers and payers become more closely aligned, which in turn supports goals of managing cost, utilization, and quality of care.

At its simplest, healthcare costs are the product of a simple equation: *Total Cost = Price × Volume*.* In health care, this equation means *Total Healthcare Cost = Provider Payment × Medical Utilization*. To manage the cost of health care, both factors—provider payment and medical utilization—must be addressed; it is not just how much is paid for each medical good or service, it is also how often is that medical good or service provided. This chapter focuses on provider payment (price) and Chapter 5 addresses medical utilization management (volume).

We will look at common methods used by private payers to pay physicians as well as hospitals and facilities. As we discuss these methods, we will consider how many payment methods are modified on a case-by-case basis, an issue that affects hospitals more than physicians. We will also examine payment methods that include some level of risk and reward sharing based on overall cost goals. Other methods combine physician and hospital payments, including some new forms under the Affordable Care Act (ACA), and may or may not include some form of risk sharing. We will briefly look at payment for drugs and for ancillary services as well.

Our focus here is mostly on payment methodologies used by commercial payers. Some types of Medicare payment methods are included because many private payers use similar or related methods, and because federal provider payment policies can affect the entire market. But payment under the Medicare and Medicaid programs is not otherwise the subject of this chapter.

Before we examine different methods of provider payment, we must first address the difference between payment and reimbursement and what makes that important. Following that we briefly look at some aspects of payment that can affect any type of payment to any type of provider. This includes how cost-sharing fits into provider payment, the standardized code set requirements relevant to billing and payment, the distinction between risk-based and non-risk-based provider payment, and value-based-payment. Once that stage is set, we explore some of these common forms of provider payment that may apply to professionals such as physicians, facilities such as hospitals, ancillary services, and pharmaceuticals.

Most of the terms used for provider payment clearly apply to only one methodology, but some terms such as Case Rate, Global Rate, Global Fee, and Bundled Payment may be used for more than one type, which can be a little confusing. This chapter will be as specific as possible, but in the real world, it is sometimes necessary to clarify exactly what or who a payment term applies to, and not make assumptions.

A final note before we dive in. This is the second longest chapter in this text, and perhaps the most complicated for someone who has not already been exposed to the stunning variety of ways that we pay for health care in the United States.† For that reason, the reader

* The equation may be simple, but it is simple in much the same way that "$e = mc^2$" is simple—meaning it is not so simple when you look at the details.

† Having said that, the chapter barely covers only the very most basic elements of some of the more common provider payment methodologies. Provider payment methodologies in the United States mutate faster than a radiated bug in a bad 1950s Sci-Fi movie. Making it worse, most payment methods are modified by different payers and the specifics may vary widely even though the same term is used. And of course, once a payment methodology appears, it rarely disappears.

may find it helpful to review the chapter in sections rather than all at once.

It's Not Reimbursement. It's Payment

On the two sides of the payment coin (so to speak), what is a cost to one party is revenue to another. In health care, what is a cost to a patient and/or a payer is revenue to a provider, and reducing healthcare costs means reducing revenue to at least some providers. And even though we might like to think that health care is or should be above such motives, it is not.

Most of us—physicians, payer executives, hospital managers, drug manufacturers, and others—have a natural inclination to maximize our own income, at least up to a point. This is not a bad thing in itself, though we tend to consider it a bad thing when we apply it to one of *them* (i.e., a physician or hospital executive if you are a payer executive, or a payer executive if you are a physician, or almost all the above if you are a consumer, and so on). But it is not inherently bad, just inherent in nearly all of us.

That brings us to this singular and important point: *Provider payment is payment; it is not reimbursement*.

Using personal income and expenses to illustrate this, reimbursement means being made whole for actual out-of-pocket expenses on a dollar-for-dollar basis—for example, being reimbursed by an employer for out-of-pocket business travel expenses. Reimbursement works the same way for everyone (not counting expense account padding, which is a minor form of fraud); in our example, work-related out-of-pocket expenses are reimbursed dollar-for-dollar in the same way for a corporate vice president as they are for a sales trainee. For that reason, reimbursement does not influence behavior other than by making a person more willing to do something like job-related travel because the employee knows doing so will not cost him or her any money.

Payment, in contrast, makes up a person's wages or salary, any type of work-related bonus, or anything else that affects income. It is not the same for everybody. Wages and salaries for example, typically vary based on training, education, and skill levels; how much an employer wants or needs to hire someone based on what that person can do; and the negotiating strength of both parties. In this sense, payment most definitely drives behavior, from basic compensation to productivity and achievement bonuses, to providing an entrepreneur the incentive to start a new business. This is also the case in provider payment.

Why is it important to make the distinction between provider payment and provider reimbursement? While it might seem to be a minor difference in vocabulary, it is not: Referring to payment as payment helps us *see* it as payment, which in turn helps us better understand its impact. Thinking of provider payment as reimbursement reduces our awareness of how payment affects personal and organizational behavior, along with its impact on costs, and even why payment methods and amounts vary so much. It leads us to incorrectly believe that healthcare costs are immutable, like a force of nature that we must bear. It can cause us to subconsciously think of payment as being fairer and more neutral than it really is—that is, as being above such tainted motives as profit or personal enrichment; a comforting fiction, but a fiction nevertheless.

That is not to say that all healthcare providers are driven primarily by money.* They are not; they are usually far more motivated by the desire to help sick patients, improve health, treat disease, and relieve suffering. Within that context, however, payment still influences behavior. Sometimes direct behavior is affected, such as when payment amounts consciously or subconsciously motivate some

* The same can be said about executives for that matter, but executive payment is not the topic of this chapter.

doctors to perform high-paying procedures or tests when they also derive income from the facility or testing device itself.

Payment also influences behavior on a larger scale. For example, specialists, especially surgical subspecialists, are paid more than primary care physicians (PCPs)—usually a lot more. In turn, medical students are choosing to become specialists instead of PCPs, resulting in too many specialists but a shortage of PCPs in the United States, the very opposite of what society needs right now.

Payment methods are not by themselves necessarily good or bad, although some align better than others with the goals of managing costs and improving outcomes. Even when they are better aligned, payment methods alone will not succeed in achieving those desired outcomes. At best, payment incentives will support management of utilization and quality; at worst, they will work against those ends.

Cost Sharing

Before addressing provider payment by payers, it is worth remembering that members pay providers too, even for covered services. As previously addressed in Chapter 2, cost-sharing by a health plan's members includes copayments, coinsurance, and deductibles. Cost-sharing is factored into all payment methods used with network providers, and an example will be shown in Table 4.4 that includes cost-sharing examples in the context of some other aspects of provider payment. And as previously noted in Chapter 2, cost-sharing does not need to be uniform for all types of services; for example, cost-sharing for prescription and specialty drug coverage is almost always substantially different than it is for medical/surgical care.

Standardized Code Sets

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made the use of certain diagnostic and procedure codes mandatory, but only for electronic transactions such as claims and claims payment between covered entities, including providers and payers. As a practical matter these codes are used even when paper bills are submitted by mail or fax if for no other reason than payers will not pay a bill that does not use them, regardless of how the payer received it. HIPAA also mandated certain standardized electronic transactions, identifiers, and privacy and security, which are addressed in Chapter 6 and listed in Table 6.1. Code sets are addressed here because they are at the center of most forms of provider payments.

The standardized code sets mandated by HIPAA are listed in **TABLE 4.1**. There are some other code sets that HIPAA does not require covered entities to use, but that may be required by Medicare and/or be commonly used by commercial payers, and these are listed in **TABLE 4.2**. Note that the code sets not mandated by HIPAA may not be self-contained code sets, but instead may be created by using mandated code sets to produce different codes. For that reason, nonmandated code sets could also be considered more as a framework for payment methods than actual code sets.

Payment can also be affected by modifiers to many of these codes that can change the method or the amount of payment depending on various factors. Modifiers codes are often standardized by the same organizations responsible for maintaining the basic code sets seen in Tables 4.1 and 4.2 but may be negotiated as part of a payer-provider contract.

Finally, HIPAA also requires the use of standardized remittance advice remark codes (RARCs) when paying providers, and payers are not allowed to use their own adjustment codes. The RARCs inform providers what was covered by the plan, how much (if anything) is being paid by the plan, and how much the provider must collect from the member. There are similar codes used for members' explanation of benefits (EOBs) statements.

TABLE 4.1 Standardized Code Sets Mandated by HIPAA

Code Set	Type of Usage
Current procedural terminology, fourth revision (CPT-4)	Procedure or type of service by physicians and other providers for inpatient and outpatient care.
Healthcare common procedural coding system (HCPCS)	Codes used by many different types of providers. Level 1 codes are CPT-4, Level 2 codes are for ambulance, equipment, supplies, and so forth for which there are no CPT-4 codes.
International classification of diseases, 10th edition, clinical modification (ICD-10)	Used to report diagnoses in all clinical settings. ICD-10 replaces Volumes 1 and 2 of ICD-9-CM, and ICD-10-PCS replaces Volume 3.
National drug codes (NDC)	Used for drugs and biologics.
Code on dental procedures and nomenclature (CDT)	Used for dental procedures and services.

Listed code sets from Federal Register for 45 CFR Part 162.

TABLE 4.2 Commonly Used Code Sets Not Mandated by HIPAA

Code Set	Type of Usage
Diagnosis-related groups (DRGs)	For inpatient care. Replaced with MS-DRGs by Medicare and being phased out by most commercial payers that used it, except for other types of DRGs as listed below.
Medicare Severity DRGs (MS-DRGs)	For inpatient care; used by Medicare and many commercial payers; replaced DRGs in most cases.
Other types of DRGs	DRGs not included among the MS-DRGs used by Medicare. See Table 4.9.
Ambulatory payment classifications (APCs)	Used for ambulatory facilities by Medicare and some commercial payers.
Ambulatory payment groups (APGs) and Enhanced ambulatory patient groups (EAPGs)	Proprietary ambulatory facility code sets related to APCs and used by many commercial payers and state Medicaid programs. EAPGs have largely replaced APGs.

Risk-Based Versus Non-Risk-Based Payment

The different types of provider payment methodologies can be risk based or non-risk based. Risk-based payment, which is generally confined to HMOs, means that the provider shares some portion of financial risk for medical costs. This serves to align the financial goals of the provider with those of the payer and/or employer. The HMO's medical costs are more predictable, and if the providers are able to help control costs, they may earn more income than they would under a non-risk-based payment system.

Non-risk-based payments do not align those goals, and higher costs equate to higher payment to providers through increases in price and/or volume. Most provider payment is non-risk-based.

Any payer, including an HMO, may use any type of non-risk-based payment. In contrast, only HMOs may use risk-based payment, and until the ACA was passed, exceptions to this rule were very limited. The ACA, however, created a new type of integrated healthcare delivery system (IDS) called an accountable care organization (ACO) for the traditional Medicare program. Medicare ACOs are required to move toward a Medicare Shared Savings Program (MSSP) payment two-sided model that includes shared risk, and many commercial payers are also using shared savings with ACOs, albeit in different ways. Organizational aspects of ACOs are discussed in Chapter 3, but payment under MSSP is discussed in this chapter.

Value-Based Payment

There is a category in between the non-risk-based and risk-based payment methodologies, and it falls under the vague label of VBP, a somewhat loose term that usually refers to payment being affected by both costs and quality or outcomes. What makes VBP a loose term, beyond differing ideas of what has value, is that it may apply to any type of provider, may focus mostly on cost or on quality, and there are no standard definitions or methods in place with one exception. That exception is the traditional Medicare Fee-for-Service (FFS) program for several payment methodologies that will be described in this chapter. Unlike Medicare, which strictly defines how it applies its forms of VBP, commercial payers, may apply the term to almost any type of payment in which the amount of payment can vary based on metrics beyond procedure and diagnostic codes.

VBP is almost always based on non-risk-based payment methods that are then modified based on various metrics beyond those used for coding FFS charges. Some types of VBP may appear to be risk-based, but usually not to the same degree as the risk-based payment methodologies described in this chapter. Because it is so diffuse, and because it modifies other forms of payment, VBP is addressed in several places in the chapter.

Physician Payment

Many different methodologies are used to pay physicians. These payment methods may differ based on many factors or combinations of factors; for example:

- The type of health plan or payer
- Benefits design
- Physician location
- Physician specialty
- Physician organizational structure
- Negotiating strength of either party
- State and federal laws and regulations

Physician payment methodologies are anything but uniform, and the same payer may pay the same physicians in the same locations for the same procedures using different methods of payment and/or different

payment amounts for different products or plan designs.*

Medical policies may also affect payment; for example, a second surgeon attending an operation is typically paid half the fee paid to the primary surgeon. In the same markets, competing payers may use different payment methods, and the same payer may use different payment methods in different geographic regions. In short, it is nearly impossible to know how, and how much, physicians are paid by any one commercial payer in any one market.

To make things even more confusing, the personal compensation for most physicians is not directly affected by the payment methodology used. Most medical groups and IDSs that employ physicians pay them a salary with bonus. Independent physician associations (IPAs) are often paid through capitation, but the IPA pays its participating physicians through some form of FFS arrangement. These and other examples show how payment methodologies by payers do not always directly affect individual physicians. And physician payment methodologies created with the specific intent of influencing their behavior may not achieve that goal because it may make up only a small portion of a physician's total amount of compensation.

Both risk-based and non-risk-based payment may be used to pay physicians, though like provider payment in general, most physician payment is not risk-based. Nevertheless, a considerable number of HMOs still use risk-based physician payment, although this varies by region. **TABLE 4.3** lists common non-risk-based and risk-based physician payment methodologies used by commercial payers; it does not include payment methods that combine professional and facility payment.

Finally, as noted in Chapter 3, the specifics of how a medical professional or facility will be paid is usually found in an appendix or an attachment to the main provider contract. This allows the terms to periodically change without having to renegotiate the contract and allows the same contract to apply to multiple different products, different types of providers, and different payment methods.

Non-Risk-Based Physician Payment

All types of payers, including HMOs, may use physician payment methods that do not share financial risk with the physicians. Even HMOs that use risk-based payment also use non-risk-based methods for at least some participating physicians, except for HMOs that globally capitate an IPA. And even then, they typically use FFS to pay for emergency or authorized care from out-of-network providers. As mentioned already, capitated IPAs frequently pay their physician members through FFS. There are some non-risk forms of payment other than FFS, and even though FFS may be the predominant form of physician payment, there is more than one way to implement it. But FFS and its variations are the most common means of paying physicians, so that's where we will begin.

Fee for Service

FFS payment is simple on its surface, but its use is complex. On the surface, a physician bills for services based on CPT-4 procedure codes, meaning what service(s) or procedure(s) were performed. The complexity is just below the surface and comes from the number of codes, the differences among them, modifiers to many codes, the fees a physician charges for each code, other codes that are added to the bill, and more.

Many believe that FFS is one of the most important drivers of cost inflation because it rewards physicians for doing more, for charging more in general, and for doing procedures with higher payment compared to less costly options. There is much truth to this

* If you are not confused yet, the author suggests you reread this sentence.

TABLE 4.3 Common Non-Risk-Based and Risk-Based Physician Payment Methodologies Used by Commercial Payers (*Payers May Use Multiple Methods with the Same Physicians for Different Products*)

Non-Risk-Based Physician Payment	HMO Risk-Based Physician Payment
■ Fee-for-service • Straight charges • Usual customary or reasonable (UCR) allowed fees • Percentage discount on charges • Fee schedule • Relative value scale (RVS) • Resource-based relative value scale (RBRVS) • Percent of Medicare RBRVS • Special fee schedule or RVS multiplier ■ Facility fee add-on ■ Case rates and global fees	■ At-risk FFS • Fee percentage withhold • Budgeted FFS ■ Capitation • Variation factors • Age and sex • Level of illness (acuity) • Other ■ PCP only ■ With a withhold ■ Without a withhold ■ Pooled vs. individual risk ■ Specialist ■ Global ■ IPA ■ Contact capitation

statement, but like so many things in health care, it is not as simple as it sounds. Even so, this concern is one reason why there are so many different ways of paying physicians, including different methods of FFS payment.

Discounts on Charges. Payment using a simple discount on charges has been used by both HMOs and PPOs. The advantage associated with this approach is that it is extremely easy to implement. Most physicians will gladly accept a discount on fees if it ensures rapid and direct payment and being listed in a plan's network directory. But the relentless upward pressure on fees remains in full force, and the discount system does nothing to reduce the rate of cost inflation. Because of this, payment through discounted charges is relatively uncommon among large payers, though it still appears in many rental PPO networks (see Chapter 2).

Fee Schedules; the Maximum Allowable Charge; and Usual, Customary, or Reasonable Fees. Except in the case of Part B services paid under the traditional FFS Medicare program (see Chapter 7), providers, including physicians, may charge whatever they want to charge*. As a result, charges vary widely from one provider to the next. Charges also usually differ by specialty and by location. Even different physicians in the same specialty and in the same community may have different charges. As a result, fees charged for any procedure may vary by as much as 500% or even more between physicians, though most are within a somewhat narrower range. Physicians are also prohibited from sharing information about their fees with

* The Medicare Limiting Charge prohibits non-participating providers from charging more than 15% of the amount paid by Medicare, but only in the traditional FFS program. It does not apply to private payers.

competing physicians because this could lead to price fixing, and so they do not necessarily know what others are charging.

Payers cannot simply pay whatever any provider charges. If they did, providers would continually inflate their fees more than they already do. To address this issue, payers use fee schedules for processing claims and determining payment amounts. A fee schedule is simply a list of the maximum amounts that will be allowed—the maximum allowable charge—for each type of service for purposes of benefits coverage and claims payment. For nonemergency services, there is typically no coverage for charges higher than the maximum, though how that affects plan members depends on each member's use of the plan's provider network and other requirements. As a side note, a physician's charges might potentially be below the maximum allowable payment, but that situation has become extremely rare or even nonexistent.

Payers use fee schedules not only to pay in-network providers, but also for the amount of benefits coverage of charges from nonparticipating physicians for nonemergency care in those plan types that offer out-of-network benefits coverage. Plan network provider contracts contain clauses prohibiting a contracted provider from balance-billing a member for any difference between the maximum allowable charge (meaning the fee schedule) and what they originally charged (see Chapter 3). Nonnetwork providers have no such prohibition. We can illustrate how this works by considering the example of a member covered under a PPO.

Most PPO benefits use fixed copayments for in-network physician office visits and percentage coinsurance for out-of-network physicians, though they may use coinsurance even for in-network physician services associated with procedures. Most PPOs also apply different deductible amounts to in-network services versus out-of-network services. This is illustrated in **TABLE 4.4**. To keep matters extremely simple, the example shown in Table 4.4 ignores any deductible and copayments, using only coinsurance to look at how the maximum allowable charge is used for in-network and out-of-network coverage.

In this example, the amount of coinsurance paid by the member for in-network care is calculated as a percentage of the maximum allowable charge or in-network fee, not the full charge. That is because the coinsurance is a percentage of the total cost of the service when it is rendered by a network provider and is therefore limited by the No Balance Billing clause in the provider contract. This level of protection is not available for charges from out-of-network providers.

The other thing to bear in mind about this example is that while covered benefits in a PPO are usually subject to cost-sharing differentials only, there may be some cases in which even a PPO provides no coverage for non-emergency services provided by an out-of-network provider. This usually occurs when non-network providers charge fees that are far, far above the in-network allowable payment, or for specific specialized services such as a stay in an intermediate facility.

Payers may use any of several ways to determine what the maximum allowable charge should be for covered claims from noncontracted providers. The historical method is known as the UCR. Where once it was defined as usual, customary, and reasonable, it is now often defined as usual, customary, *or* reasonable. The definition of reasonable is in the eye of the beholder, and payers often determine that certain services are overpriced—sometimes grossly so—for reasons discussed below.

The traditional or historical approach to determining prevailing fees is to collect data for charges by CPT-4 and HCPCS codes in a defined region (e.g., a city); calculate the 10th, 25th, 50th, 75th, and 90th percentiles*;

* A percentile means the percentage of providers who charge the same or less than an amount. For example, if the 10th percentile is $50.00 and the 90th percentile is $500.00, then only 10% of physicians charge $50.00 or less, while 90% of physicians charge $500.00 or less.

TABLE 4.4 Example of the Use of Maximum Allowable Charge in a PPO

Benefits Differential	In-Network Benefit: 80% Coverage	Out-Of-Network Benefit: 60% Coverage Based on Maximum Allowable Charge
Fee charged by physician	$200.00	$200.00
Maximum allowable charge	$150.00	$150.00
Amount paid directly to participating physician	$120.00 (80% of $150.00)	$0.00
Amount paid by the PPO to the member[1]	$0.00	$90.00 (60% of $150.00)[2]
Amount paid by the member to the provider	$30.00 (20% of $150.00)[3]	$200.00
Net cost to member	$30.00	$110.00 ($200.00 minus the $90.00 covered by the PPO)[4]

[1] Unless required by state law, health plans typically do not directly pay noncontracted providers, except for emergency care in some cases. The member is responsible for paying the provider, and the covered amount is sent by the plan to the member.
[2] There is no coverage for charges higher than the maximum allowable charge.
[3] Contracted providers agree to not balance bill the member for any difference between the PPO's maximum allowable charge fee schedule and their full charges.
[4] Benefits coverage is limited to a percentage of the maximum allowable charge, not a percentage of the provider's charges. Because they do not have a contract with the PPO, out-of-network providers are not required to limit how much they charge and may pursue payment in full. The member must pay the provider the entire amount but receives a check from the PPO for the amount that is covered.

and then choose which percentile represents a reasonable maximum prevailing fee, which traditionally was the 90th percentile. Unfortunately, this approach drives price inflation: When enough providers raise their fees to a higher level, that also increases the average charges—resulting in higher charges at all percentiles, including the 90th, which in turn encourages providers to raise their fees once again. In a similar way, the rare physician charging less than the maximum allowable charge will raise their charge and not leave money on the table.

A small number of physicians take this to an extreme and charge fees that are 10–20 times higher than average, which can drive the percentiles very high. Payers once used statistical techniques to reduce the impact of excessively high physician charges on the UCR calculation, but a lawsuit by the Attorney General of New York that was settled in 2009 stopped that practice*. Therefore, payers typically combine UCR data with other sources of fee information such as Medicare payment rates to determine the maximum allowable charge for each code. Increasingly, payers no longer use UCR

* The successor organization for maintaining a fee database has since reintroduced a method of addressing extreme fee outliers.

data at all, but instead simply base their maximum allowable charges on Medicare fees, increased by a fixed percentage.

Even though it might appear that a physician can earn more money by not contracting with any payer and charging full fees, it is not always easy to collect that money. Indeed, sometimes those fees are never collected at all, although some states now require payers to pay even noncontracted providers directly. In most cases, being in a network means getting paid directly, thereby avoiding at least some problems with collection. Patients are also more likely to see in-network physicians, and contracting physicians are not likely to lose patients because of cost differences.

Relative Value Scale and the Resource-Based Relative Value Scale. The use of an RVS is widely used in FFS. Each CPT-4 or HCPCS procedure billing code has relative values associated with it called relative value units (RVUs). The plan pays the physician based on a fixed dollar amount multiplied by the value of the RVUs. This fixed dollar amount is called the Multiplier or Conversion Factor. It allows a payer to update a fee schedule simply by changing the multiplier rather than having to recalculate each fee separately.

A simple RVS that reflects UCR fees will also reflect the higher prices associated with procedures compared to office visits. To correct this imbalance, the simple UCR-based RVS has, in most cases, given way to the resource-based relative value scale (RBRVS), though not for all specialties; for example, anesthesia services are billed under a special version of an RVS that allows for different amounts of time.

The most well-known RBRVS is the one used by the Centers for Medicare & Medicaid Services (CMS) for Medicare. At its most basic, for each CPT-4 code, three different RVUs are added together to make up the overall value. RVUs may also be affected by Geographic Practice Cost Indices (GPCI) values, and certain codes may also be affected by different modifiers; both are described below. In the traditional Medicare FFS program, RBRVS FFS is used to pay professionals, and is subject to periodic modification by CMS.

The three types of RVUs are:

1. The Physician Work Component, which includes:
   - The time required to perform the procedure or service
   - The degree of technical skill and physical effort required
   - The degree of mental effort and knowledge reflected in the amount of resources invested by the physician in training
   - Psychological stress associated with the risk to the patient.
2. The Practice Expense Component, which includes:
   - The average cost (based on surveys) of running a physician's practice, including the cost of personnel, supplies, and so forth, by specialty
   - The presence of costly diagnostic and therapeutic equipment, based on the equipment not sitting idle
   - A modification based on where the procedure or service was provided, which may lowers the value for procedures performed in a facility such as a hospital and raises it for procedures performed at a non-facility such as an office
3. The Professional Liability Insurance Component, which is the average or expected cost of malpractice insurance, by type of specialty.

GPCI are used to adjust for the average relative costs associated with physician work, practice, and professional liability insurance in a locality compared to the national average relative costs.

Modifiers are used in conjunction with certain CPT-4 and HCPCS codes. These reflect differences in costs specific to a case, such as the number of procedures performed at any one time, the number of allergens used for injected allergy treatments, the length of anesthesia, and so forth.

Value-Based Payment Modifiers (VBPM) that apply to some specialties were created under provisions of the ACA. This is a modifier to the overall payment amounts under the traditional Medicare FFS program that is based on how well a physician or medical group scores on its reported quality-related metrics. It is now incorporated into Medicare's new payment methodologies described later in the section.

TABLE 4.5 provides a simplified example of the calculation of the allowed fee for a routine office visit (CPT-4 Code 99213) using an RBRVS scale and the Medicare Conversion Factor, also called the Multiplier, amount for 2018. For purposes of simplicity, we will ignore the impact of the GPCI and of potential modifiers, including the VBPM.

Most payers now use Medicare's RBRVS as the basis for their FFS fee schedules, often by simply adjusting the value of the multiplier by some percentage (e.g., the Medicare rate plus 15%).* However, the Medicare RBRVS is not the only scale in use because it does not cover all procedures, so commercial payers may also license an RBRVS scale from an external source. Both may be used depending on the types of services provided. Payers also may use other types of schedules for services not typically addressed by an RBRVS.

The value of the multiplier is usually the same for all physicians in the network in the same general area, but large medical groups and hospitals with large numbers of employed physicians may negotiate a higher rate from commercial payers that must have that system in their network. Special rates make claims processing more complex and add to administrative costs, but it is increasingly common as the providers consolidate.

Balance Billing When a Member is Unable to Choose a Provider

Balance billing has been described in several places in this book, including how network providers are prohibited from using it, and how it applies when members receive non-emergency care from an out-of-network provider. But there are situations in which a member has no ability to choose the provider. This is also sometimes called "surprise billing"

TABLE 4.5 Simplified Illustration of RBRVS Payment Calculation for CPT-4 Code 99213 (Routine Office Visit), Ignoring GPCI and Modifiers

Step 1	Step 2
Calculate total RVUs for CPT code 99213: ■ Work RVU = 0.97 ■ Non-facility practice expense RVU = 0.99 ■ Professional liability cost RVU = 0.07	Multiply total of RVUs by the fixed-dollar amount conversion factor: ■ Total RVUs = 2.03 ■ Multiplier or conversion factor amount = $35.99
Total RVUs (0.97 + 0.99 + 0.07) = 2.03	Allowable payment amount (2.03 × $35.99) = $73.06 (not factoring in GPCI or modifiers)

* Private Medicare Advantage plans typically pay physicians at rates close to Medicare, but payment rates for commercial products are usually higher.

and there are two common situations in which this can occur.

The first situation occurs if an attending physician orders a consult or receives care from a non-network specialist, which may happen during surgery when the patient is not even awake. This situation also arises when hospital-based physicians such as radiologists, anesthesiologists, and pathologists at a participating hospital do not contract, which is discussed in Chapter 3.

The other situation is confined to emergency room (ER) services. As discussed in Chapter 5, the ACA prohibits payers from requiring precertification for emergency services at an in-network level of benefits, if it meets a prudent layperson standard (defined in Chapter 5). The ACA does not have any provisions applicable to providers regarding participation or payment, however.* ER physicians often do not contract with any payers, even when they practice at a participating hospital, and they typically have very high charges. The plan usually must pay them in full except for the in-network amount of cost-sharing, as long as it meets the reasonable layperson standard. Payers usually try to address this during contract negotiations as described in Chapter 3, but it is not always successful.

Either of these situations may expose members to costly balance billing for care from providers that they had no ability to choose. A few states have addressed this problem by prohibiting out-of-network providers from balance billing in such situations and a few are considering it, but most states have not addressed it at all.

Add-on Facility Fee

The increase in the number of physicians employed by hospital systems has been accompanied by an increase in separately billed facility fees associated with physician office visits. In other words, a hospital that runs the clinics or offices used by their employed physicians bills the payer a separate fee. It is a separate bill from the facility, not the physician, but is noted here because payments to physicians practicing in their own offices include all the costs associated with providing care, and no extra fee is paid for office space or support because it is included in the RBRVS Practice Expense Component. But an add-on facility fee is rarely offset by a lower physician charge, and because the service or procedure was technically performed in the physician's office, there is no automatic offset to the Practice Expense Component. Medicare, however, requires physicians to use a different Place of Service (POS†) code to indicate if a visit was in the physician's office or in a hospital-owned facility, and reduces the payment amount to a physician when services are provided in a facility that bills separately. But Medicare requirements are not binding on billing private payers or individuals.

When payers contract with hospitals that charge an add-on facility fee, they typically negotiate that fee out of the payment and require the participating hospital to not balance bill the member. When the payer does not have enough negotiating leverage to do so, or if the system is not in the payer's network, however, members may find themselves facing an unexpected additional cost that is usually not covered in their benefits.

Case Rates and Global Periods

A case rate is a single payment that includes all professional services delivered in a defined episode of care. It may also be called a Global Period. Global Periods are defined for certain HCPCS code used for physician billing and payment of surgical and obstetrical services,

* An unrelated law requires ERs and ER physicians to screen and stabilize any patient who appears in the ER, regardless of ability to pay, but it does not prohibit balance billing.

† POS in this context is a billing code and not to be confused with a Point of Service (POS) health plan.

and it can vary from 1 day to 90 days depending on the procedure.

Common examples include obstetrics, in which a single fee covers all prenatal visits, the delivery itself, and at least one postnatal visit; and certain surgical procedures, in which a single surgical fee pays for preoperative care, the surgery itself, and postoperative care. Case rates are similar to FFS in that they are event based, but they reduce the ability to unbundle charges (charge separately for items once included in a single charge) or to churn visits (see patients more often than is necessary). A case rate may be subject to additional outlier fees if significant complications occur, in which case payments are typically based on discounted charges.

Electronic Visits

Electronic visits, also called e-visits or online visits, are a clinical interaction between a physician (or non-physician provider in some cases) and a patient that takes place via electronic communications other than normal phone calls. Electronic visits must comply with HIPAA's privacy and security requirements, as discussed in Chapter 6. This compliance is usually ensured by using a specialized form of secure mobile application; a secure patient portal; or a secure, live video interaction. Some payers cover e-visits as an urgent care alternative for members with routine problems.

There are specific CPT-4 and HCPCS codes for e-visits. Most states define what constitutes an e-visit, but not in any uniform way. States often require that any provider providing an e-visit be licensed to practice in that state. Some states also require providers to have a special license to provide them. Some states require private payers to cover them, and a few require payers to pay the same amount as they would for an office-based visit.

Medicare pays for them on a limited basis, as do many Medicaid programs. Most payers also pay for providing care via e-visits, even in those states that do not require them to be covered, though the payment amount may differ from that charged for a standard office visit. Payers typically require some form of documentation and verification that a HIPAA-compliant e-visit took place. The member may be required to pay the usual copayment based on plan design, but this practice is not uniform.

Modifiers

Modifiers, which were mentioned earlier, are codes that are included in bills under non-risk and risk-based FFS and affect the amount paid for the procedure or service. For example, a procedure or service might have both professional and technical components, and therefore paid at a higher rate; or an outpatient visit might include the cost of injected drugs. There are a great many modifier codes. Because Medicare addresses modifiers in its RBRVS payment methodology, those private payers that use RBRVS typically adopt Medicare's coverage and payment policies. Payers that do not must create their own policies.

Risk-Based Physician Payment

Capitation is the most well-known method of risk-based payment, but risk-based FFS is also common, and both may be used in the same HMO or IPA. Because of concerns in past decades about risk-based physician payment—especially capitation—potentially incentivizing a physician to withhold necessary services, state laws typically allow only HMOs to capitate providers. At least initially, this same concern was one of the reasons HMOs were required to have more stringent rules about utilization and quality management (QM) than other types of plans. Ultimately, the concern about capitation leading to poor quality of care proved to be unfounded.

The limitation of risk-based payment to HMOs became blurred with the appearance of MSSP for ACOs, a topic that will be addressed later in the chapter. The MSSP is only applicable for care provided to Medicare beneficiaries

covered under traditional FFS Medicare and does not apply to private Medicare Advantage (MA) managed care plans. Medicare ACOs are not required to be licensed insurers, so the program is outside of state laws and regulations, including those affecting provider payment.

Capitation

Capitation is prepayment for services on a fixed per-member per-month (PMPM) basis. In other words, a physician is paid the same amount of money every month for every member in his or her patient panel regardless of whether that person receives services, and regardless of how extensive or frequent those services are. The exact amount is affected by multiple factors, as seen a bit later in the section.

It is important to keep that point in mind because the capitation payment rate is not the same as the payment rate for office visits. Capitation is paid whether the member comes in or not, and the same amount is paid even if the member sees the doctor only once in a year or even never.

Capitation is a predictable amount of income for providers. Equally important, it is prepaid, meaning the provider does not need to try to collect money after the fact, except for any cost-sharing such as coinsurance or deductibles (copays are typically collected at the time of service). When providers do have to collect large amounts of money owed to them for past services, they may not be able to collect it all; capitation eliminates that risk.

Capitation is used by over two thirds of the HMOs that also use a PCP gatekeeper system in which a member selects a single PCP or primary care group for services, and the PCP manages the member's access to specialty care. Because of this, utilization and costs can be attributed—directly or indirectly—to that PCP. HMOs that use capitation, other than HMOs that capitate a large IPA or medical group with both PCPs and specialists, typically capitate PCPs more often than they capitate specialists.

Capitation paid to a large physician organization usually does not mean that the individual physicians in the organization will be compensated through capitation. For example, a large medical group or a hospital system with employed physicians may be capitated, but the individual physicians may be paid via salary with productivity bonuses. Likewise, an HMO may capitate an IPA for all professional services, but the IPA might then pay its physician members through a mix of FFS and capitation or even entirely through risk-based FFS as described below.

This variety of options illustrates that how a health plan pays its contracted physicians and how the physicians themselves are personally compensated are not the same thing. On top of that, most physicians or physician organizations contract with multiple payers, each of which uses different forms and amounts of payment. Even the same payer may pay physicians differently based on product design; for example, it may use capitation for its HMO product but use FFS for its PPO.

Lock-In Requirements and Scope of Covered Services

One key requirement if capitation is to work is that members must be locked in to a specific provider or provider group and not covered for nonemergency services obtained from another provider unless first authorized by the capitated provider or the HMO. Plan types in which members are free to access any network provider make it difficult to attribute costs and utilization to any one physician. Capitating physicians in an open access plan also leads to double payment through capitation to one physician and FFS to another.

The other key requirement for successful capitation is that the contract with a capitated physician must define which services are included and which services are not included.

Excluded services are also referred to as "carve-outs" because they are carved out of the capitation payment, and are addressed later in the section. Services typically included are such things as preventive services, outpatient care, emergency on-call coverage, and so forth. Certain services require more definition than other things; for example, selected diagnostic testing (e.g., office urinalysis or electrocardiograms) may be included in the capitation, but for other lab testing the patient might be sent to a free-standing outside reference lab. This concept applies to any type of medical service a capitated physician or group may provide.

Calculation of Capitation Payments

The actual dollars and cents paid in capitation varies by product design and is based on a few other factors. Product design affects the total amount of payment because any copayments paid by members are accounted for in calculating the overall payment. For example, if a patient sees a PCP 4.2 times per year and the HMO sets a target to be the equivalent of an average revenue of $75.00 per office visit, then the total capitation for each member would be $4.2 \times \$75.00 = \$315.00$ per member per year (PMPY), or $\$315.00 \div 12 = \$26.25$ PMPM.*

That $26.25 is not the monthly capitation payment, though. It would be only if the HMO paid for the entire office visit, but members typically pay a copayment for each visit. In this example, we will assume that the copayment is $20.00. The calculation, then, must deduct the copayment amount from the total visit cost—in this example, $\$75.00 - \$20.00 = \$55.00$. The capitation payment then uses $55.00 per visit instead of $75.00, so the calculation comes out to $\$55.00 \times 4.2 = \$231.00$ PMPY, or $19.25 PMPM. If the PCP has 100 members, the monthly capitation payment would then be $\$19.25 \times 100 = \$1925.00$.

Because most HMOs offer benefits plans with different copayment levels, the calculation is based on the mix of copayment amounts in place for the capitated physician's panel of members. Capitation monthly payment amounts may also be affected by a withhold, which we will discuss shortly.

Other factors that may affect base capitation amounts include age, gender, and geographic location. From birth to about 18 months of age, infants are seen by their doctor quite often, but much less after that. Young adults also use fewer services on average, though young women see their doctors more often than young men. As people get older, both men and women use an increasing amount of medical services, and men continue to use less than women, though the differences are smaller. Location has an impact related to the overall cost of living; access to care; differing cultural norms about seeking medical care; and costs to providers for maintaining medical offices and other facilities, hire personnel, and other medical support costs.

HMOs that offer point-of-service (POS) products face difficulties when calculating capitation rates. Capitation is usually calculated based on the capitated physician providing all appropriate services for a defined panel of members, while a POS plan also provides benefits for services provided by a PPO provider (in a triple-option POS plan) and/or an out-of-network provider. Consequently, some services will not be provided by the capitated physician, so the usual way of calculating capitation will overpay that provider. If a capitated medical group or IPA is large enough, the HMO can include in the capitation rate the cost of out-of-network services. In contrast, if capitation is based on individual physicians or small groups, that method is not reliable. This has led some HMOs that offer POS plans to abandon capitation and revert

* All numbers used to show how capitation works are for illustration only and should not be considered as representing accurate visit costs, utilization rates, or capitation rates.

to FFS payment, which can be used regardless of benefit design.

Withholds and Risk Pools

HMOs that capitate PCPs may apply additional forms of capitation-related PCP financial risk and reward through withholds with financial risk pools for non-primary care costs. Close to half of all open panel HMOs use withholds, but only one-quarter of all closed panel HMOs do. Withholds and risk pools may be used with individual physicians, medical groups, or IPAs, though less so with IPAs and large medical groups. Capitated IPAs may even set up their own withholds and risk pools.

The example that follows looks only at its use with individual PCPs or small groups. A simplified generic illustration of withholds and risk pools is seen in **FIGURE 4.1**.

A withhold is simply a percentage—for example, 20%—of the primary care capitation that is withheld every month and held for use to pay for cost overruns in referral or institutional services. Each month, the PCP would receive the capitation minus the withhold amount. To illustrate this, we will use the example of a PCP capitation amount of $19.25 for members with a $20.00 copay. A 20% withhold would be $3.85, so the PCP would receive $15.40 PMPM each month. If the PCP has 100 members, then he or she would be paid $1540.00 every month, with $385.00 going into the PCP's withhold account.

The withhold money, $3.85 PMPM in this example, is held by the plan and used at year's end to pay for cost overruns for services allocated to the risk pool or pools for non-primary care, though less commonly it may be applied to cost overruns for the entire HMO. The amount of money allocated to risk pools is calculated based on average of the expected costs for the services to which the risk pool could be applied. Any remainder in the withhold is returned to the PCP, but the amount received by any physician or medical group may also be affected by metrics from the plan's QM program (see Chapter 5). HMOs that capitate also set up a risk pool for "other" to cover costs such as stop-loss protection for PCPs, pharmacy costs, and so forth.

HMOs typically calculate both the capitation payment rate and the withhold amounts so that lower than expected costs results in higher revenue compared to FFS, not just the avoidance of a loss in payment. Finally, both the capitation calculation and the impact of utilization and cost on a withhold are often

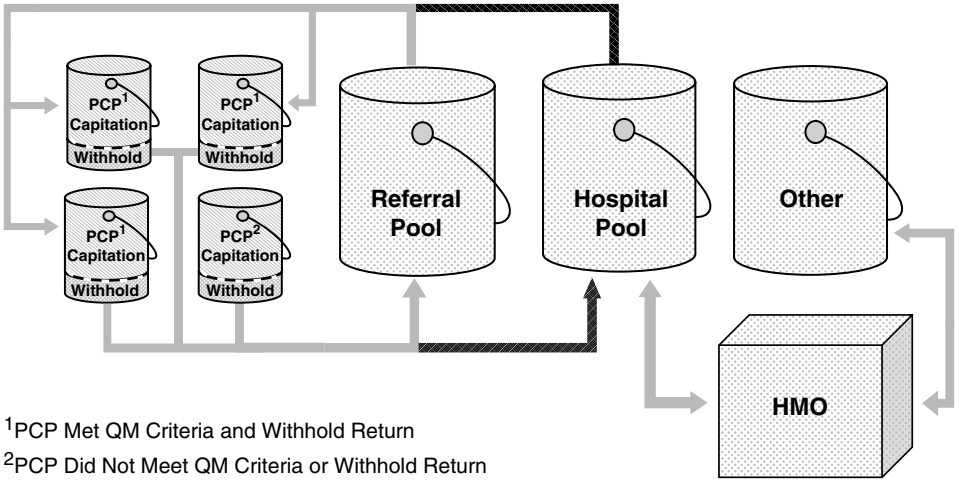


FIGURE 4.1 Simplified Generic Illustration of Capitation Risk Pools

affected by carve-outs and outlier provisions, which are described a bit later, and by stop-loss protection that is described next.

Stop-Loss Protection

HMOs nearly always include "stop-loss" provisions, meaning ways to reduce the impact of particularly costly cases that could otherwise deplete the risk pools all by themselves. The risk of having a costly case is often random when the total number of members is small, which they are for any individual physician, but random chance becomes less of a factor the larger the pool of members becomes. It is usually provided by the HMO, but large groups and IPAs may be allowed to purchase reinsurance on their own, as long as it complies with the HMO's requirements and any regulations that may apply.

Stop-loss means that once a member (i.e., patient) reaches a certain level of costs, the impact of the additional costs is reduced. The amount of protection is greater for individual physicians than for large groups and IPAs because random chance plays less of a role the more members are included. Some HMOs even eliminate the impact altogether and remove the member from any PCP risk pool, and management of care is then done by the appropriate specialist(s). If the HMO provides the stop-loss protection, the cost is factored into the calculations for how much capitation is paid to the PCP or group. If a large group or IPA purchases reinsurance on their own, the amount of reinsurance is not factored into the capitation amount.

Risk-Based Fee-for-Service and Budgeted Fee-for-Service

Capitation is only one type of risk-based HMO physician payment. Another option uses FFS payments and withholds, and sometimes by the application of mandatory fee reductions or budgeted FFS. When withholds are used, the same approach is applied as for capitation; rather than withholding a percentage of the capitation payment, however, a percentage of each fee is withheld. This option may be used for PCPs only, or for all physicians in an HMO or IPA. Stop-loss is often used as well.

Budgeted FFS refers to a form of risk-based FFS in which an across-the-board reduction in the fee schedule is applied when costs exceed a target, and does not usually involve withholds. It is less commonly used than is risk-based FFS with withholds. Cost targets may apply to the entire covered population, or targets and fee reductions may be segmented by specialty.

Carve-Outs and Outliers

Carve-outs refer to services not included in a risk-sharing payment program; more accurately, it refers to services not included in any specific payment methodology, as will be seen later. Outliers refer to patients whose costs exceed some threshold. Carve-outs and outliers are much more prevalent in hospital payment, where they are addressed more fully, but may apply to physician payment as well. It is more common for carve-outs and outliers to be used in risk-based payment, such as capitation, but may be used with case rates too.

An example of a carve-out would be the cost of vaccinations under PCP capitation because physicians cannot afford to stock all required vaccines, and the cost of vaccines can change abruptly. Another example of a carve-out would be a procedure that is not included under capitation and is billed separately. An example of an outlier would be the high cost of care for a member with serious complicated conditions, in which the costs above a certain amount would no longer be applied against a capitation risk pool, or even taken out altogether as part of a stop-loss provision.

Physician Pay for Performance

Pay for performance (P4P) may be considered a form of VBP, though usage of the term P4P has been around longer than VBP, and the methodology has been used before it was called P4P. Not to be left behind though, the label of VBP is now frequently applied over

many P4P programs that have been in place for years. This is logical, and it may be more appropriate name if a payment methodology has P4P imbedded within it.*

P4P commonly refers to financial incentives aligned with the practice of evidence-based clinical care, though some P4P programs add other measures too. P4P is based only on incentives rather than being risk-based and is used on top of some other form of payment. P4P began in HMOs in the 1980s, though it went by different names, but is now widely used by many types of payers as well as Medicare. Unfortunately, nearly all P4P programs used by commercial payers differ from one another, at least in part, which creates a potential administrative burden on providers.† For most P4P programs, it is not clear if there has been a beneficial impact, though they do not have a harmful one.

P4P programs typically apply to PCPs but may involve specialists, an IPA, or a medical group as well. P4P arrangements often share many or even all of the following attributes:

- Common conditions
- Conditions for which physicians vary in how they treat cases
- Conditions for which there are good evidence-based medical guidelines
- A payer's ability to measure performance using data it has on hand, such as medical and pharmacy claims data.

For example, patients with diabetes should have their eyes examined, including a retinal exam, regularly because these individuals have a higher than average risk of blindness. The payer can use its claims data to see if diabetic patients are visiting an eye doctor to have the test performed. In some cases, data from focused PCP medical chart reviews, and physician self-reported data may also be used for P4P, particularly when P4P metrics include a type of medical service does not necessarily generate a claim.

The financial incentive for providers is usually based on target percentage compliance with several such measures. The higher the compliance rate, the higher the incentive payment. There will also be a minimum compliance rate below which there is no incentive payment. Physician P4P programs usually look at the performance of groups of physicians because there are usually only a small number of measures that any individual physician may be able to report. Exceptions include common process measures for certain individual physicians in primary care—for example, immunization rates.

The Medicare Access and CHIP Reauthorization Act of 2015 and the Quality Payment Program

The Medicare Access and CHIP‡ Reauthorization Act of 2015 (MACRA), in addition to reauthorizing CHIP for 2 years, put in place a new and very complex VBP methodology for physicians and other professionals in the traditional FFS Medicare program only. It may also be thought of as a form of P4P. This new VBP methodology is called the Quality Payment Program (QPP); it is sometimes also referred to as MACRA. Physicians who are below a low-volume threshold of $30,000 in allowed Medicare charges, or 100 Medicare patients, are not affected.

It is beyond the scope of this book to cover Medicare beyond the MA and Part D programs described in Chapter 7, but the QPP under MACRA is included here because it is a

* Or it could be seen as slapping yet another new label on old bottle, but it's probably better to take the more positive view.

† The exception is in California where most of them rely on a uniform set of metrics under a nonprofit coalition called the Integrated Healthcare Association (IHA, found at https://www.iha.org).

‡ CHIP, sometimes referred to as SCHIP, is the State Children's Health Insurance Program for covering qualifying low-income children via a state's Medicaid program, though it is not itself Medicaid and requires regular reauthorization. As of the date of publication, it has been authorized through 2023.

highly complex methodology that may, in part, be adapted by some commercial payers. Like nearly all federal programs, including MA, it is also a festival of acronyms that the reader is likely to encounter in the payer industry.

The QPP has two pathways for professional payment: The Merit-Based Incentive Program (MIPS) and Advanced Payment Models (APMs); there is also a third nonpathway for professionals exempted from either program. Professionals are paid through MIPS or APMs, but not both. There are a great may different modifiers under this system and billing codes are likewise more complex, but well beyond the scope of this text.

Finally, like so many issues involving the federal government and health care following the 2016 election, MIPS and APMs have undergone changes since MACRA was passed and is continuing to face changes even at the time of publication. Readers should therefore check up-to-date sources about some of the provisions described in this section as necessary.

Merit-Based Incentive Program

Professionals paid under MIPS are assessed in four annually updated performance categories, which can be positive or negative:

1. Quality
2. Resource use (based on the value-based modifier program measures)
3. Electronic Health Record (EHR) meaningful use requirements
4. Clinical practice improvement activities, such as care coordination and population management

Advanced Payment Models

Professionals who receive a certain share of their Medicare-related revenue through APMs are exempt from MIPS requirements. Those who participate in APMs also receive a larger increase in annual Medicare base payment rates.

Some forms of APMs existed before the passage of MACRA and are described in various places in the chapter. Examples include the MSSP that is used for ACOs, episode-based payments, and capitation. Whatever the APM is, MACRA requires that the APM organization must require professionals to use a certified EHR, be measured on quality metrics to some degree, and bear more than nominal risk. At the time of publication however, there is no definition of what more than nominal risk means. Finally, MACRA also authorized the creation of a Physician-Focused Payment Models Technical Advisory Committee to recommend even more new forms of VBP as well.*

Facility Payment

Facilities refer to hospitals, health systems, and ambulatory procedure facilities—in other words, to the physical facilities in which care is provided and that bills for its services separately from physician billing.

Types of Facility Payment

As with physicians, there are a few dominant forms of payment, but experimentation has produced many variations on those common approaches and created some entirely new methodologies. **TABLE 4.6** lists the most common facility payment methodologies. Sometimes only one method is used, but the same payer will often use different payment methods or amounts for the same hospital for different products—for example, HMO, PPO, and MA products. Except when charges or discounted charges are used for all services, outpatient facility payments differ

* This provides a good illustration of one of the most confusing aspects of provider payment in the United States: We continually create new and increasingly complex provider payment methodologies but eliminate virtually none of the old methods. Some hope that these new methodologies will solve our problems, but at best they can only reduce the amount of problems caused by other payment methods.

TABLE 4.6 Common Facility Payment Methods

Facility Payment Method	Inpatient	Outpatient
Straight charges	X	X
Discounted charges	X	X
Per diem	X	
DRGs—old phased-out method	X	
Medicare Severity DRGs (MS-DRGs)—currently used method	X	
Percentage of Medicare allowable	X	X
Case rates—facility only (may be bundled with professional), see also Episode Treatment Groups (ETGs™)	X	X
Capitation (HMOs only)	X	X
ETGs™*	X	X
Ambulatory surgical center rates under the Medicare Hospital Outpatient Prospective Payment System (HOPPS)		X
APCs		X
APGs and Enhanced APGs™ (EAPGs™)*		X
Other	X	X

* APGs, EAPGs, and ETGs are registered trademarks owned by 3M™.

from inpatient payments. Most facility payment methods are also subject to modifiers beyond carve-outs and outliers, that alter the payment on a case-by-case basis; **TABLE 4.7** lists the most commonly used payment modifiers. Neither Table 4.6 nor 4.7 includes payment methods that combine facility and physician payment, which are discussed separately.

Before going on to discussing some of the specific types of facility payment, it is worth touching on three things that can affect—directly or indirectly—the types and amounts of payment: The hospital chargemaster, carve-outs, and outliers.

The Chargemaster

All of a hospital's or ambulatory facility's charges are listed in its chargemaster. The typical hospital chargemaster may contain between

TABLE 4.7 Common Hospital Payment Modifiers

Facility Payment Modifier	Inpatient	Outpatient
Volume-related sliding scale—potentially applicable to all but full charges or capitation	X	X
Carve-outs—potentially applicable to all types of payment except straight charges	X	X
Credits—potentially applicable to all types of facility payments	X	X
Differential by service type—potentially applicable to per diem	X	
Outlier or stop-loss—potentially applicable to all types of payment except charges	X	X
P4P and VBP—potentially applicable to all types of payment	X	X
Penalties and/or refusal to pay—potentially applicable to all types of facility payments except capitation	X	

15,000 to 50,000 separate billing codes and associated charges,* as well as codes that modify the charges for various reasons. The chargemaster is used to generate the complex bills that hospitals now create, and it is usually the basis for how hospitals determine their prices regardless of which payment methods are used by the payers it contracts with. In other words, even facility payment methods that are not explicitly based on the chargemaster are still affected by it.

Chargemasters are like flakes of snow: No two are alike, and the charges and the internal codes in each chargemaster differ from facility to facility. Chargemaster charges also typically have only a general relationship with actual costs. There are several reasons for this disconnect, including the difficulty in tracking and allocating costs, challenges with associating those costs with individual cases, and the need to include nonclinical but necessary costs, such as the cost of building maintenance, the cost of leasing and maintaining an information technology system, wages and salaries paid to clinical and nonclinical personnel, and so forth. Except in the case of a pass-through cost—an implanted device, for example—the chargemaster reflects only a relative difference in the amount of resources used, and many costs are spread to all the charge codes.†

Another important reason why chargemasters differ is that hospitals, like all providers, are free to charge whatever they want in their chargemasters, at least for private-pay

* Some large teaching hospitals and health systems may have up to 100,000 different chargemaster codes. Ambulatory procedure facilities typically have far fewer.

† This is what accounts, at least in part, for anecdotes such as a $25.00 charge for an over-the-counter pain pill.

patients and commercial payers. Hospitals typically adjust their chargemasters every year by making a small number of adjustments to charges for specific services, adding new codes and charges for new services or devices, and then increasing all of the remaining charges by a percentage amount applied across the board.

Hospitals and outpatient facilities that contract with private payers usually agree to payment terms that equate to less than full charges, but they negotiate those terms by using financial models based on their chargemaster; Medicare uses a different approach. Maryland is currently the only exception to this; in that state, an independent commission sets global revenue targets and payment rates for each hospital, and those payment rates are used by all public and private payers, including Medicare.

Carve-outs and Outliers

Facility payment methodologies may incorporate many types of modifiers, and these will be described in the context of each type of payment as appropriate. But before describing the different common methods of facility payment, it is important to note two specific types of modifiers that can affect almost all forms of facility payment: Carve-outs and outliers. These factors are different and are not mutually exclusive, and can affect any type of payment to facilities other than payment based on full charges.

Carve-Outs

Hospitals and ambulatory facilities typically seek to carve expensive surgical implants, devices, or drugs out of the payment method and pass their costs through to the payer, along with a markup. Because of the high costs of some devices and drugs, this practice may or may not be unreasonable, but carve-outs also eliminate any incentive for the hospital to negotiate prices with its own vendors or to get physicians to agree to use only the products from a limited number of device manufacturers. Facilities also usually seek to carve out certain types of procedures from a type of payment, or at least negotiate different terms.

Payers seek to limit the number of contractual carve-outs to provide that incentive, and to better control case costs. This is particularly the case when the volume of the implantable device or the expensive drug is high, and therefore predictable. Payers also typically limit the amount of markup a provider may add to the pass-through cost. Because markup charges are typically based on a percentage of the cost of the device or drug, payers may limit the percentage to a fixed level such as 7% or may only cover a fixed dollar amount rather than a percentage of the cost. Carve-out charges may also be affected by rebates to hospitals from manufacturer warranties on devices that needed early replacement, which payers usually require hospitals to also pass along.

Outliers

Outliers refer to extra payments allowed if a patient's costs exceed certain thresholds. This practice is also not an unreasonable protection, but it is worth noting that cases are usually classified as outliers based on how the hospital determines costs, which in turn are typically based on the hospital's chargemaster. Because of that, price increases in the chargemaster result in more cases being considered outliers even for cases that would not have been considered outliers prior to an increase in the chargemaster. Payment for outlier cases is typically a combination of the original payment plus discounted charges beginning at the point where the outlier threshold was crossed. Depending on the type of payment and the negotiated terms, over time as many as one-third or more of all inpatient cases may be classified as outliers.

Charges

Charges and discount on charges may be used for inpatient and/or outpatient cases. There are several ways in which charges, as found in

the chargemaster, may be used as the primary basis for payment to facilities, including discounted charges and a sliding scale discount on charges as described shortly. Charge-based payment may also be combined with non-charge-based payment under certain circumstances. Payment terms directly related to charges are the least desirable payment method because they are highly vulnerable to price inflation.

Straight Discount on Charges

A straight percentage discount on charges is a contract in which the facility submits its claim in full and the plan discounts it by the agreed-to percentage, which is considered payment in full other than any applicable cost sharing by the member. Straight discount on charges is a method that was once frequently used for inpatient services but is now uncommon other than in some rural areas. Discount on charges is sometimes used to pay a hospital for outpatient and emergency department services, even when a payer uses another payment methodology for inpatient care.

To address price inflation, a payer may negotiate a provision to cap the level of annual price inflation on what they pay. The payer cannot tell the facility what it can charge others, however. In other words, the facility is free to raise chargemaster fees as much as it likes, but the payer's exposure is limited to a certain percentage increase.

Sliding-Scale Discount on Charges

Sliding-scale discounts are another payment option. With a sliding scale, the percentage discount reflects the facility's total volume of admissions and/or outpatient procedures. Like straight discounts, sliding-scale discount on charges was once more widely used than it is now, though when it is used, it is more likely to be for outpatient care instead of inpatient.

Per Diems

Per diem is Latin for "By the day," and per diem payment methods apply only to inpatient cases. Unlike payment methods using charges, a per diem payment is a single fixed payment for a day in the hospital regardless of any actual charges or costs incurred. For example, the plan pays $1900.00 for each day regardless of the actual cost of the service. Per diems are predictable and provide savings for shorter lengths of stay, unlike some other types of payment such as DRGs or MS-DRGs; even so, their use has declined over the years. There are different ways that per diem payment can be implemented.

Flat per diems means a single per diem rate is negotiated and applied to any type of inpatient day. In other words, the payment for a day in the intensive care unit is the same as for a day for a routine medical patient. Because of the high differences in costs, service-specific per diems are more common in acute care hospitals.

Service-specific per diems means that negotiated per diems differ based on service type; examples include different per diems for medical–surgical care, obstetrics, intensive care, neonatal intensive care, rehabilitation, and so forth. Service-specific per diems also reduce the need to negotiate outlier provisions. Service-specific per diems can be combined with differential by day per diems described next.

Differential by day per diems, also called front-loaded per diems, are based on the fact that most hospitalizations are more expensive on the first day. For example, the first day for inpatient elective surgical cases includes the admission, pre-operative prep, operating suite costs, the operating surgical support team costs (nurses and recovery), and so forth. The same can be said of each type of medical-surgical type of service, though the amounts differ. Because of this, the first day is paid at a higher rate. For example, the first day may be paid at $4000.00 and each subsequent day is $1200.00. Differential by day per diems typically include service-specific per diems as well.

Sliding-scale per diems, like sliding-scale discounts on charges, are based on total volume and can be used with any type of per diem. It is not commonly used.

Inpatient Diagnosis-Related Groups and Medicare Severity Diagnosis-Related Groups

DRGs, which were initially developed for Medicare, are broadly referred to as the Inpatient Prospective Payment System. They provide a flat payment per admission and apply only to inpatient cases. DRGs place responsibility on the hospital to manage the inpatient stay. Savings from shorter stays are kept by the hospital and do not go to the payer, whereas longer stays usually do not cost the payer more unless it is an outlier.

Under DRGs, the number of cases being classified as outliers has continually risen over the years. To deal with this trend, Medicare changed from DRGs to MS-DRGs, and the "MS" stands for "Medicare Severity." MS-DRGs better incorporate severity of illness and complications into the payment system, reducing the need to classify outliers. When they replaced standard DRGs, the number of cases classified as outliers did fall, but it did not take long for them to increase again.

DRGs and now MS-DRGs are sorted into 23 major diagnostic categories (MDCs), each of which represents a system in the body and whether or not the patient had surgery. Within each MDC, DRGs are assigned by a grouper program based on the mix of diagnoses, procedures performed, age, sex, discharge status, and presence of complications or comorbidities (i.e., medical problems in addition to the one that resulted in the admission). In other words, DRGs are created through the submission of other code set data and supplemented by additional information.

As seen in **TABLE 4.8**, several forms of DRGs exist, though two have been phased out (phased-out DRG types appear in italics in Table 4.8). The reason for the different types of DRGs is that Medicare DRGs and MS-DRGs were intended for use by Medicare

TABLE 4.8 Types of DRGs

Type of DRG	Acronym	Developer
Original Medicare DRGs—replaced by MS-DRGs	DRGs or CMS-DRGs	3M[1] for CMS
Medicare Severity DRGs	MS-DRGs	3M for CMS
All Patient DRGs—replaced by APR-DRGs	AP-DRGs	3M
All Patient Refined DRGs	APR-DRGs	3M and NACHRI[2]
All Patient Severity DRGs	APS-DRGs	OptumInsight[3]
Department of Defense DRGs	Tricare DRGs	3M

[1] 3M™ is a private for-profit corporation.

[2] National Association of Children's Hospitals and Related Institutions, a nonprofit association of children's hospitals.

[3] OptumInsight™, also known as Optum™, was formerly known as Ingenix™, and is a private for-profit subsidiary of United Health Group™.

and, therefore, do not have the same types and levels of detail needed for commercial populations of members representing all ages and all types of specialized care.

Many commercial payers therefore supplement DRGs or MS-DRGs with another type such as All Patient Refined DRGs (APR-DRGS) that cover a broad range of patients and provide a more robust form of severity adjustments. Like DRGs, the earlier version called All Patient DRGs (AP-DRGs) has been phased out and does not comply with ICD-10.

Tricare, the health benefits program for the uniformed services, use their own version of DRGs that are similar to that used by Medicare, but have a different cost basis and different weighting. Presumably out of habit, many people still use the term DRG as a short-hand reference to any of the DRG types.

Many commercial payers negotiate rates based on a percentage markup of whatever Medicare would pay for similar services. Such rates may vary from as low as Medicare plus 5% to as high as Medicare plus 60%, and the percentage often varies by type of product such as MA, HMO, and/or PPO.* For cases that must use a DRG type other than MS-DRGs, a similar calculation is applied, but in those cases the other DRGs do not necessarily come with pricing attached; consequently, negotiated payment terms are usually described in more detail.

Facility-Only Case Rates

Facility-only case rates may be used for inpatient and/or outpatient cases and refers to a flat payment for a defined service. They differ from DRGs in that they may apply to both inpatient and outpatient services and are typically used for only defined types of cases. Facility-only case rates are like bundled payment and episodes of care, but do not include professional fees; bundled payment and episodes of care that include physician payments are described later. Unfortunately, the term episode of care may also be used by some to refer to facility-only case rates, so one needs to check. Case rates may be used in combination with other types of facility payment.

An example of a common type of facility-based case rate is for obstetrics, with the payer and facility negotiating a flat case rate for a normal vaginal delivery and a flat rate or case rate for a cesarean section, or a blended rate that combines both. Case rates for specialty procedures at tertiary hospitals are also not uncommon—for example, for coronary artery bypass grafts, heart transplants, and certain types of cancer treatment. Inpatient cases other than those subject to case rate payment are paid through another method. Case rates are also used for defined types of outpatient procedures, such as screening colonoscopies and cataract surgery.

Bundled payment, sometimes called package pricing or global payment, refers to use of a single fixed fee covering all facility services related to a defined episode of care or a procedure. The exact same term may also be used when physician services are included, as described later in this chapter. CMS has a program with multiple bundled payment models call the Bundled Payments for Care Improvement (BPCI) Initiative that is described later.

A bundled payment might cover multiple types of procedures, or more often a different bundled payment is set for each type of procedure. Like capitation, the services covered by the bundled payment must be well defined. Unlike capitation, bundled payments are paid only for services provided, not month in and month out. Episodes may sometimes be defined using ETGs. Bundled payment is typically subject to modification by outliers and/or carve-outs.

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* In markets with many competing hospitals and with a great many seniors (for example South Florida) some MA HMOs may pay slightly below Medicare's payment rate.

Penalties and/or Refusal to Pay for Avoidable Readmissions or Serious Reportable Events

As previously noted in Chapter 3, many payers include contractual provisions for financial penalties or conditions under which the plan will not pay some or any portion of a hospital claim, and the hospital may not balance bill the member. In addition to non-payment for failure to comply with UM requirements, two other potential penalties may apply: One applying to avoidable readmissions, and the other to costs associated with Serious Reportable Events (SREs), also sometimes called "Never Events."

Avoidable Readmissions

A provision of the ACA requires CMS to reduce Medicare payments to hospitals that have a higher than expected rate of avoidable readmissions, and most private payers now include this in their contracts too. An avoidable readmission is defined as a readmission to the hospital less than a set number of days, usually 30, after discharge for certain clinical conditions such as heart failure or pneumonia. It does not apply to an admission for reasons other than the one the patient was originally admitted for. No hospital is expected to have no avoidable readmissions, and non-payment is usually applied only when the percentage of them exceeds some threshold.

Serious Reportable Events

Medicare and most commercial payers refuse to pay anything for the cost of avoidable complications that occur in a facility or for any care associated with an SRE. An SRE is defined as a serious health or safety error, or a criminal violation that takes place in a hospital, such as the amputation of a wrong limb or a serious error in prescribing or administering a drug. SRE definitions are regularly updated by a nonprofit organization called the National Quality Forum.

Capitation

Unlike physician capitation, facility capitation by HMOs is uncommon. Even HMOs that capitate one or more hospitals do not capitate all hospitals in its network. When it is used, the HMO pays the facility on a PMPM basis to cover all institutional costs for a defined population of members, as was described for physician capitation. The payment may be adjusted based on the age and sex of the population, but not always if the capitation covers a large enough group of members. Severity-adjusted capitation is still relatively uncommon but is starting to be used by some HMOs. Capitation can be used for inpatient as well as outpatient services.

Hospital capitation contracts typically define both carve-outs and outliers. Outlier provisions also lower the amount paid under capitation, and costs not included under capitation are usually paid on some form of discounted charges. Capitated hospitals usually also purchase commercial stop-loss or reinsurance to cover a portion of high-cost inpatient cases, but for reasons described in Chapter 2, reinsurance does not always provide full protection.

Ambulatory Payment Classification and Ambulatory Patient Groups

Although the discount on charges method is often used to pay for hospital-based outpatient services, it is not the only method nor the preferred one, and payers are increasingly using EAPGs (or the older APGs) and APCs, especially for free-standing ambulatory facility payment; all were created by the company 3M.

APGs, EAPGs, and ACGs are to outpatient services what DRGs are to inpatient services, although they are calculated very differently. APGs were developed as a forerunner of APCs, and the two are quite similar. APGs have subsequently been updated as EAPGs. Under these payment methods, the thousands of different procedures are

grouped into hundreds of different treatment groups. Such a group includes all ancillary costs, but certain items are carved out, such as particular drugs, the cost to acquire transplanted tissue, and so forth. Compressive APCs do not have carve-outs. Payments may also be adjusted for geography and complexity of the procedure. Commercial payers generally use EAPGs (or APGs) more than they use APCs, which is what Medicare uses exclusively.

Hospital Pay for Performance

There is some overlap between P4P programs focused on hospitals and those focused on physicians, including the increasing use of the term VBP instead of P4P. The actual measures, however, tend to be different. P4P programs for hospitals measure results for individual hospitals or health systems, whereas physician programs usually look at the performance of groups because there are usually only a small number of measures that any individual physician may be able to report.

P4P programs are dependent on a variety of data collection approaches, which can lead to inaccuracies if they are not managed properly. Consequently, leading payers maintain openness to improvements in methodologies for data collection. Unfortunately, as with physician P4P, payers use different, though overlapping measures, potentially increasing the administrative burden on hospitals as well.

Combined Payment of Hospitals and Physicians

Payment for both physician and facility services may be combined rather than paying for each type of service separately. Several approaches are possible, but four common methods, listed in order of prevalence and degree of financial risk, are:

1. Bundled Payment, also called package pricing, global payment, or (less frequently) case rates
2. Episode of Care, also called Episode of Treatment when ETGs are used to define an episode
3. Shared Savings—one-sided and two-sided
4. Global Capitation

Successful bundled payment contracts all have one thing in common: The hospital and physicians have a predetermined way of dividing the payment, and all involved providers agree to those terms. The payer is not involved in this internal arrangement. When bundled payment contracts fail, it is typically because this aspect of the deal—that is, the division of the payment—is not solid. Academic medical centers with a unified faculty practice plan, very strong multispecialty medical groups with an affiliated medical center, and health systems with a large panel of employed physicians are best able to address this.

Bundled Payment

Bundled payment was described earlier for facilities only, but it can also be used when payment of hospitals and physicians is combined, using a single fixed fee to pay for all facility and professional services related to a defined episode of care or a procedure. It is the most commonly used form of combined payment to hospitals and physicians, though even so, it is not overly common. In general, it is similar to that described for hospital-only bundled payment.

The ACA specifically requires bundled pilot programs for FFS Medicare, and CMS was testing several of them until the fall of 2017. Confusingly, the bundled payment under the early models used by CMS did not include physician services, only hospital. But in the fall of 2017, CMS cancelled the mandatory hip fracture and cardiac bundled payment models and implemented changes to the Comprehensive Care for Joint Replacement (CJR) Model

by reducing the number of areas that CJR was mandatory. In 2018, CMS introduced the BPCI Advanced model as a voluntary program with 32 clinical care episodes for participating providers to choose from. The BPCI now has models that include physician payment. All of which is quite confusing at best. But there is still room for more confusion because the BPCI models used by CMS include a type of shared savings if costs are lower than set targets, similar (but not identical) to Shared Savings discussed shortly. All are considered a form of VBP of one kind or another. The BPCI program is more complicated than what is typically found in the commercial sector, but that could change over time. **TABLE 4.9** lists the four active (and one inactive) BPCI models as of 2018.

Episode of Care

Payment for an episode of care, or less commonly called an episode of treatment, is a form of bundled payment that extends to a period after discharge, and sometimes before discharge too. It is similar to a facility-only case rate, but it includes payment for facility and physician services, and usually extends for a longer time both before and after the period that usually applies to a case rate. Defining an episode may be negotiated between a payer and a facility, but it is more common to use an automated classification system such as ETGs. ETGs were initially developed by 3M for clinical reasons, not payment, but are nevertheless useful in defining episodes of care for purposes of payment.

The Medicare Shared Savings Payment Programs

In the past, shared savings referred to a payment method in which cost targets were set for an episode of care, and savings were shared between the payer and the provider. The term may still be used this way, but the ACA includes a requirement that Medicare implement the MSSP for use with ACOs for traditional FFS Medicare (ACOs are discussed in Chapters 1 and 3). It is included here because it is also used by some MA plans and by private payers for commercial products. However, there is no uniformity to how private payers, including MA plans, implement it, or even

TABLE 4.9 CMS Bundled Payments for Care Improvement (BPCI) Models for Traditional FFS Medicare as of 2018

BPCI Model Type	Providers Included in BPCI Model
Model 1 (concluded Dec. 31, 2016)	Inpatient hospital services only
Model 2	Inpatient hospital services, physician care, post-acute care, and readmissions
Model 3	Post-acute care and readmissions
Model 4	Inpatient hospital services, physician care, and readmissions
Advanced (Oct. 1, 2018)	Inpatient hospital services or outpatient procedure, physician care, post-acute care, readmissions, and hospice services

Data from Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement (BPCI) Initiative: General Information. (2018). Retrieved from https://innovation.cms.gov/initiatives/bundled-payments/

define an ACO. However, it is still worth being acquainted with the MSSP at a high level.

MSSP is a hybrid VBP payment methodology, combining FFS with some elements of risk-sharing, the MIPS program described earlier, and P4P, which is discussed later in the chapter. The MSSP program has three and a half tracks as of 2018, though CMS may change that as they have before. Track 1 is a one-sided model that has no risk, and the ACO is only eligible for a shared savings bonus if it qualifies. Track 1+ is a two-sided risk with low levels of shared risk and shared savings. Tracks 2 and 3 are two-sided models with increasingly higher levels of shared risk and savings for an ACO that qualifies. All but Track 1 also qualify as APMs under MACRA that was described earlier in the chapter.

There are two major aspects that set it apart from methods described up until now for combined payment of hospitals and physicians. One is that it is based on a defined population of people, not an episode of care, procedure, or defined event. The other is that the two-sided tracks are one of the few exceptions to provider risk sharing that does not involve an HMO, which is possible because the Medicare MSSP program applies only to traditional FFS Medicare and is therefore a purely federal program, not subject to state laws or regulations. At the time of publication however, most Medicare ACOs under MSSP are in the one-sided track.

In the Medicare program, for purposes of measuring performance, an ACO must have at least 5000 assigned or attributed* beneficiaries who are only in the traditional FFS Medicare program, not in an MA plan. Which beneficiaries are attributed to the ACO is determined by CMS, not by the ACO. CMS assigns beneficiaries based on whether they receive primary care from an ACO-participating PCP or whether most charges come from ACO participating providers. Assignment or attribution in this program simply means the member is attributed to the ACO for purposes of measuring performance. Assigned beneficiaries are not locked in; that is, they are not restricted to using only ACO providers. Beneficiaries can see any provider they want with no benefits differential.

The goal of the MSSP is to reduce overall costs, particularly the costs associated with individuals who have significant or multiple chronic conditions, as well as improve certain quality-related performance metrics. CMS calculates overall cost benchmark targets for the group of beneficiaries assigned to the ACO by including their actual incurred costs in the immediate past. In other words, benchmark cost targets are not based on the overall costs of all beneficiaries in the same area, but rather are specific to the assigned beneficiaries. Benchmark targets are also adjusted for other factors such as medical cost inflation, location, and level of illness. Quality-related metrics similar to those used for the MIPS program described earlier are also measured against targets.

From a day-to-day payment perspective, ACO providers are paid under traditional Medicare terms: FFS for physicians, MS-DRGs for hospitals, and APCs for ambulatory facilities. ACO performance against the benchmark targets, however, determines whether the ACO participants may be eligible to receive a portion of the shared savings as an additional bonus or whether they will share in the losses and repay a percentage of what they were paid initially. It is included in the discussion on combined payment because of this shared risk and reward aspect.

Reducing costs to below target levels is not enough, however. Shared savings bonuses are only paid if the ACO also achieves or exceeds quality and service target measures. Physician payment under an ACO MSSP is considered an APM under the Medicare QPP as described earlier, so physicians participating in an ACO are not included under Medicare's MIPS program.

* Both terms are used interchangeably but attributed is the more accurate term.

As complicated as all this sounds, CMS also has an ACO APM applicable to physician-only and rural ACOs that includes an up-front fixed payment, an up-front payment based on the number of attributed beneficiaries, and monthly payments that are also based on attributed beneficiaries. ACOs may also have an APM based on partial or global capitation (discussed below), bundled payment, and/or episodes of care.

Shared Savings Programs by Commercial Payers

Shared savings payment methods used by commercial payers tend to be one-sided, meaning that savings against a target are shared with the ACO, but not losses. Bonus payments usually also require the ACO to meet or exceed certain quality or outcome measures. Commercial payers that have agreements with ACOs typically use it with non-HMO products. For products that are insured by the payer, it is not clear if states will allow any form of risk-sharing but may allow some forms of gain-sharing. Self-funded plans administered by payers are not subject to state regulation and therefore have more flexibility to share risk for any type of plan, but as a practical matter, payers do not use different shared savings methods for insured vs. self-funded plans.

Global Capitation

Global capitation means HMO payment of a single entity for all medical services, although some costs, such as pharmacy charges, are often carved out. Said another way, global capitation is the near-complete transfer of risk to providers for professional- and facility-related costs. It requires a single entity to accept the single capitation payment and manage all care. Global capitation in past decades led to significant losses by health systems that were unable to manage the risk, and since then it has been uncommon in most parts of the United States, though it has not disappeared entirely. A type of global capitation has been increasing over the past several years as some health systems have started their own health plans to cut out the middleman, though that strategy has, like the last time it appeared, lost popularity.

Global capitation, like bundled pricing, requires the hospital and physicians to have predetermined policies about how the payment will be shared, and payment methods should be aligned. For example, paying physicians using FFS creates potential losses for a globally capitated IDS unless the physicians are part of an experienced IPA. Hospitals and health systems with large panels of employed physicians are at least potentially well positioned to accept global capitation. Strangely enough, health systems that operate their own health plans generally do not have much alignment, however. Adequate reinsurance is a requirement in any event.

Price Transparency

The term price transparency or pricing transparency, sometimes also referred to as cost transparency, refers to making information about hospital and/or physician pricing available to consumers. Many or most states have passed legislation requiring that some type of pricing information be made available to consumers, and some states have created an all-state database for that purpose. In most cases, transparency means facility chargemaster prices. Charges by individual physicians are difficult to obtain and to post, so when physician charges are posted at all, they usually represent an average.

For private payers, transparency usually means providing members access to comparisons to what it will cost them out-of-pocket for in-network vs. out-of-network non-urgent care for a specific type of procedure or visit. It is not common however, for a payer to reveal to the public at large what it pays a specific hospital or facility for all services. Those terms

are almost always the subject of confidentiality clauses in the contract. In any event, payers rarely pay full chargemaster prices to network hospitals. In the case of physicians, payers may make available the averages they pay for specific procedures, though even then it's an average of potentially different amounts, and provider-specific payment terms are usually subject to confidentiality clauses.

Members who receive care are provided some information after the fact when they receive an EOB document once their health plan has processed the claim or claims. For in-network care, for example, the EOB tells the member how much the plan allows in charges, how much of that was paid by their health plan, how much must be written off by the provider and not balance billed to the member, and how much the member is responsible for paying. But this is not generally considered price transparency because it is a mix of coverage determinations and negotiated prices, and amounts covered by the plan are typically rolled up into a few totals, not broken out by specific charges.

Many or even most consumers say they want price transparency, but it is less clear how many make use of it, and payers with comparison tools have seen very little member usage. In addition, the costlier medical interventions such as inpatient stays or diagnostic evaluations usually vary based on individual needs, meaning that any comparisons can only be based on averages. In all events, consumers are far more focused on their own out-of-pocket costs, not the payment rates; if there is no difference in a member's deductible or coinsurance for a high-cost vs. a low-cost provider, then there is little or no impact on consumer choice.

While many people believe that making fees or charges transparent will lead to lower costs due to competition, this has not been proven, and there is some evidence that it leads to increases in charges and payment amounts. In other words, the old ceiling becomes the new floor when providers charging less than the highest amounts may increase their charges to catch up. When transparency is based on actual payment rates negotiated by private payers, providers who are paid less than other providers demand increases in payment rates. There are no examples of providers concluding that they are overpaid and voluntarily reducing charges.

Payment for Ancillary Services

Ancillary services are broadly divided into two major categories and two minor ones. One major category is diagnostic services, such as laboratory testing, imaging studies, cardiac studies, and the like. The other major category is therapeutic services, such as physical or occupational therapy. That category also includes vendors of durable medical equipment (DME) and supplies, but it is addressed in the section on payment for prescribed drugs instead of here. One minor category is medical transportation, including ambulance and scheduled medical transportation. The other is custodial care, which is covered only by Medicaid and only then for those with few financial assets.

Many ancillary services are among the first to be carved out of provider networks, meaning limited to a small number of contracted providers, to take advantage of cost reductions based on economies of scale through volume increases to the contracting provider. It is also reasonable to require plan members to travel farther for nonurgent ambulatory ancillary services. Strict limits on benefits coverage may be applied, except in the case of emergency care, even for those plans that offer coverage for both in-network and out-of-network services. This concept applies to any type of plan, but HMOs often have the smallest number because it allows them to more easily capitate for ancillary services.

In certain areas, there may be little competition between ancillary service providers—

for example, in a rural area or a very small town—in which case the payer has less negotiating leverage. Ambulance services are another area where there is typically little competition, plus ambulances are frequently summoned on a non-elective basis, both of which have an impact on payment policies; non-urgent medical transportation is usually more competitive. Conversely, in competitive markets in which ancillary services providers do not require exclusivity, some payers do not limit the number in the network and still obtain favorable pricing.

There are no payment methods applicable only to ancillary services, although some are less suitable than others. A brief description of common payment methods follows.

Fee-For-Service, Discounted Fee for Service, or a Fee Schedule

Payers generally avoid paying FFS for high-volume ancillary services such as routine blood testing but are more likely to use it for high cost testing and therapeutic services. Payers rarely cover the full FFS charge for non-emergency ancillary services and are much more likely to pay based on a maximum allowable charge or fee schedule, similar to that described earlier. Fee schedules may also be used for outliers or carve-outs for ancillary services.

Flat Rates and Bundled Payment

As with other types of providers, flat rates simply mean that the ancillary provider is paid a fixed single payment rate regardless of the resources used to providing a service. Bundled payment refers to payment for a block or group of services, not a separate payment for each service; for example, a flat payment for a bundle of common blood tests that are often ordered together.

For therapeutic ancillary providers, flat rates and bundled rates can be tiered, like we saw in hospital per diem tiering. For example, when home health care includes high-intensity services such as chemotherapy or other high-technology services, the plan may pay different case rates depending on the complexity of the specific case.

The agreement or contract may also contain provisions for outliers and carve-outs. As an example of an outlier, a flat rate for kidney dialysis may allow for additional discounted FFS or FFS fee schedule payment for dialysis of a frail patient with brittle diabetes. A carve-out could include certain costly infused drugs that are instead paid through the payer's program for managing specialty pharmacy, which is addressed in the next section.

Capitation

HMOs frequently capitate ancillary services providers. Because stricter benefits limitations may apply to non-urgent ancillary services, even HMOs with out-of-network benefits such as a POS plan may still capitate payments and limit benefits for ancillary services to in-network providers. The benefit to the provider of the ancillary service is a guaranteed source of referrals and a steady income. Capitation also removes the FFS incentives that may lead to overutilization of provider-owned ancillary services.

Certain types of ancillary services are easier to capitate than others. If an ancillary service is self-contained, then it is easier to capitate. For example, physical therapy usually is limited to therapy given by physical therapists and does not involve other types of ancillary providers.

In some cases, a single entity accepts capitation from the HMO for all of a particular type of ancillary service and then serves as a network manager. That managing entity then subcontracts with ancillary services providers that meet the terms and conditions of the health plan. Subcontracted providers may be paid through any method, including subcapitation, which is called downstream risk, though the network manager remains at risk for the total costs of the capitated service.

Reference Pricing

Reference pricing is a type of maximum allowable payment in which the allowed payment amount is based on the best price a payer can obtain from a vendor that is accessible to a physician or member. It is used mostly for costly medical goods and services that have enough competition to allow for price negotiations. For example, a payer may cover the cost of a motorized wheelchair when it is medically necessary, but the coverage is limited to what was negotiated with a manufacturer or DME vendor; if a member wants a different type, the difference is solely the responsibility of the member. Reference pricing is also used for specialty pharmacy that is addressed in the next section.

Some ancillary services are paid through a combination of one of the methods described earlier, plus reference pricing. This is may be done when a service has a combination of professional services and some type of DME or infused drug. Two examples for home health care might be a combination of a home health nurse and DME, or a home health nurse performing infusion of a medication. In the first example, there is a different cost or charge for the professional services of the home health nurse, and the cost or charge for the equipment. In the second example, there is a cost for the home health visit, a professional cost for giving the infusion, and the cost of the infused drug. In both examples, the professional services might be paid through a flat rate, and the DME or infused drug paid through reference pricing.

Payment for Prescription Drugs

Most prescription drug benefits are not administered through a payer's usual claims system, but rather by a pharmaceutical benefit manager (PBM) that may be owned by a payer or may be an independent company contracted by a payer or an employer.

In addition to the drug manufacturers, there are three types of pharmaceutical providers: (1) pharmacies that dispense standard types of prescription drugs (the most common type), (2) compounding pharmacies that mix existing drugs together into a single compound, and (3) specialty pharmacies for very costly types of drugs. A single pharmacy may include any or all three.

Before describing some common prescription drug payment methods, it is necessary to understand that regardless of how any payment method is described, there is no simplicity at all in the real world. The same is true of all provider payment, but for the prescription drugs, payment methods are usually mixed together, they do not always involve the same parties, not all parties may be involved in a specific arrangement, and many times the involved parties do not even know what else is going on. The parties involved include:

- Drug manufacturers
- Drug wholesale distributors
- Pharmacies
- PBMs
- Payers, including plan sponsors of self-funded plans
- Members

In addition, drug manufacturers frequently raise prices multiple times per year for their costlier or more popular products. Unless there are special contractual provisions addressing that, these frequent price increases can affect all parties involved; payers, however, cannot raise prices more than once per year.

Specialty Pharmacy

Before addressing payment for prescription drugs overall, it is appropriate to describe what is generally referred to as specialty pharmacy because it has a dynamic of its own. Specialty pharmacy or specialty drugs refers to drugs that are very high-cost, complex, require special handling and more provider attention than do regular drugs. In most cases, they are used to

treat serious medical conditions in a relatively small population of people. Although some specialty drugs are oral medications, many are biologics, meaning organic molecules that must be injected or infused, and many have a high risk of serious side effects. Even so, their use has grown rapidly over the years and continues to do so.

The cost for a specialty drug is extraordinarily high and may account for up to a third of all costs combined. Each may cost between $10,000.00 and $100,000.00 per year, and sometimes much more. Price inflation for specialty drugs is far higher than for non-specialty drugs. The ACA requires coverage for drugs but does allow a difference in benefits for drug coverage than for other types of benefits, but over one third of all specialty drugs are covered under the medical/surgical (also called major medical) benefit because they are infused in a medical facility under supervision of a licensed clinician.

Many specialty drugs have no or few competitors. In other cases, there are other specialty drugs available to treat the same condition, but they may not all work the same way. And sometimes there is more than one specialty drug for the same condition, and each is relatively effective. But in all cases, the manufacturers maintain high prices.

Specialty drug manufacturers may bypass wholesalers or even pharmacies. Specialty pharmacy requires specialized benefits management, and often have different coverage policies and payment approaches compared to coverage of regular drugs.

Standard Methods of Payment

The standard method of paying pharmacies for regular drugs combines a fill fee and the ingredient cost. The fill fee is an amount that the PBM pays the pharmacy for filling a prescription regardless of the drug prescribed. For example, a PBM may pay a pharmacy $2.50 for each prescription filled.

The ingredient cost is the cost of the drug itself that a pharmacy pays a distributor. It is not easy to determine the ingredient cost because drug wholesalers may negotiate different prices with drug manufacturers, and prices paid by pharmacies to the wholesalers also vary. For example, nationwide chains are able to obtain lower prices than the few small community pharmacies that still exist can. The most common approach is for the PBM to use a standardized listing of average wholesale drug prices. This standardized price is called the average wholesale price (AWP), and a PBM commonly pays for a drug based on a percentage of AWP (e.g., 95%), but the percentages vary widely. The reason the AWP is typically discounted is that large pharmacies nearly always negotiate lower prices from their wholesalers.

Because of the wide variations in drug costs, especially between generic drugs and branded drugs, drug benefit coverage is almost always tiered. In other words, a lower copayment is required for preferred drugs, whereas progressively higher copayments or even coinsurance are required for non-preferred or less-preferred drugs.

The list of drugs covered in the various tiers is called a formulary. In a closed formulary, there is no coverage under most conditions for drugs not included in the formulary, and it may exclude some branded drugs with available generic equivalents; members and providers may be able to request an exception based on meeting certain clinical criteria. In an open formulary, all prescribed drugs are covered to some degree, but nonformulary drugs are subject to a higher level of coinsurance.

Specialty pharmacy often has its own formulary, combined with different types of coverage limitations and cost-sharing, and are subject to much closer management of utilization.

Rebates

PBMs frequently negotiate rebates from drug manufacturers, and rebates may also be negotiated by any of the other parties involved other than members. The terms for rebates are confidential and are usually not revealed

to some or all of the other parties involved in payment. Rebates may be paid directly, but are often used to offset prices.

Rebates do not apply to every drug, of course, but rather to drugs that are relatively widely prescribed and for which multiple good alternative therapies exist. For example, if six different drugs are available to treat individuals with high cholesterol levels, the PBM, payer, and/or employer group may negotiate with the manufacturers of one or two of those agents to obtain rebates based on the inclusion of those drugs in a favorable tier in the formulary.

Reference Pricing

Reference pricing, which was discussed already in regards to facility payment, is often used for very high cost drugs and specialty pharmacy. Reference pricing is also commonly used to pay for DME.

With payment through reference pricing, coverage is based on either the best price a payer has obtained from any source or the price charged by the manufacturer to the providers who administer or provide the treatment. In other words, coverage is not based on whatever is being charged to the payer. As a practical matter, for drugs with no alternatives, the best price available may not differ tremendously from the price available anywhere else, but not always. For administered drugs subject to high add-on fees, coverage is based on the best price available to the payer or PBM, plus a set administration fee—for example, 6% of the cost of the drug, and no more—which reduces the high profits that add-on fees bring. Even with reference pricing, benefits for specialty pharmacy may have a very high coinsurance requirement such as 50%.

Value-Based Payment

VBP for drugs has been appearing in recent years. It usually refers to setting certain clinical goals for a defined population of members with similar conditions that are being treated with a specific drug. For example, improving HgA1c levels—a measure of long-term blood sugar levels used to monitor diabetes—from a baseline level by a defined percentage. VBP for drugs is not common, but is sometimes used for specialty drugs for which there are reasonable therapeutic alternatives.

Continued Innovations in Provider Payment Methods

In the United States we continually change or create new methods to pay providers, though the standard methods continue to be what we most commonly use. Some changes simply keep up with advances in technology and treatment, but many represent attempts to move payment away from providing incentives to overutilize and overcharge; and more towards restraints on costs, improved quality and outcomes, and higher value. But controlling, much less reducing, costs is very difficult for many reasons, not the least of which is that what one party considers cost, another party considers revenue, so cost reductions also reduce somebody else's revenue, and few people or organizations want to receive less money.

Because the federal government is subject to payment-related costs in Medicare, it has piloted many approaches to new methods of payment for the traditional FFS Medicare program. The ACA called some of them out, as we have seen; for example:

- MSSP for ACOs, which had been a pilot program but was made into law in the ACA
- No payment for high avoidable readmission rates or for SREs, another pilot made into law
- Bundled payments, which remains a pilot program that was recently scaled back

Another major provision in the ACA focused on Medicare FFS payment reform by creating the CMS Innovation Center. The Innovation Center is to test, evaluate, and

expand different payment methodologies. Another ACA provision related to Medicare payment was the Independent Payment Advisory Board, but that was abolished by Congress in 2018.

Even if federal payment methodologies in FFS Medicare do not affect private payers directly, they have an impact for two main reasons:

1. Because Medicare accounts for such a high percentage of the total payments to hospitals and many physicians, any changes it makes in payment methodologies will affect private payers, often in unknown or unpredictable ways.
2. Where CMS goes, private payers often follow.

Payment innovation in the private sector also influences federal payment policies. Most of the payment methods described in this chapter originated in the private sector; for example, HMOs have used bundled payments for decades. Because Medicare's Part D drug benefit is provided only through the private sector, innovations in payment for drugs are almost entirely private.

It is difficult to predict what new methods of provider payment will come along. Some rational payment innovations in the past have languished or failed because they were too complex to be practical or had unexpected flaws. But innovations in provider payment can also inspire or affect other new methods. And in the U.S. healthcare system, new methods to constrain costs will continue to be met with new methods of offsetting their impact. We are an endlessly creative people.

Conclusion

Provider payment is payment; it is not reimbursement. Payment has the potential to affect behavior, whereas true reimbursement does not. Consequently, to the greatest degree possible, payment methodologies should align the financial incentives and goals of the health plan, the plan's members, and the network providers who deliver the care. Other than FFS and charges, payment methods discussed in this chapter represent attempts to achieve that alignment in ways that traditional FFS does not.

Any payment methodology is a tool, however, and like any tool it has limitations. Consider the following analogy: A hammer is the correct tool for pounding and removing nails but is a poor choice for cutting wood. Likewise, if payment methodologies are used without at least a modicum of skill and forethought, their application will likely result in a painful self-inflicted injury. Payment may similarly be a powerful and often effective tool, but it can be truly effective only in conjunction with other managed care tools: UM, QM, network contracting, provider relations, and the many other activities undertaken by a well-run managed healthcare plan.

CHAPTER 5

Utilization Management, Quality Management, and Accreditation

LEARNING OBJECTIVES

- Recognize the different approaches to managing wellness and prevention.
- Identify and describe the basic metrics and measures used to assess and monitor health plan medical costs and utilization.
- Describe the basic components of utilization management for medical services, including prospective, concurrent, and retrospective review.
- Explain the basic concepts underlying disease management, case management, transition management, and Patient-Centered Medical Home.
- Describe the basic components of quality management, including structure, process, and outcome.
- Understand the purpose and scope of external review and accreditation of managed care plans.

Introduction

The term managed care derives from the practice of managing certain aspects of medical services, specifically medical costs and population-based health quality. To be sure, these aspects are also managed by providers, but in their capacity of providing healthcare services. The only types of payers that also directly provide health care are group and staff model health maintenance organizations (HMOs), large integrated healthcare delivery systems (IDSs) that are also licensed as HMOs or insurers, and health insurers that have acquired physician practices and/or (rarely) hospital(s), but these provide both coverage and care to only a very small fraction of the U.S. population. As discussed earlier in Chapter 2, most people are covered by health benefits plans that do not themselves provide care, but rather

manage healthcare benefits coverage. In other words, health plans manage what will be paid for, how much will be paid, and under which circumstances benefits will or will not be paid.

The term utilization management (UM) is most commonly used by payers to refer to one of the set of activities a plan uses to address costs. Other terms that might be used are utilization review (UR), which is an older term, as well as care management. All of them refer to similar activities, though sometimes UR is used only for precertification. To avoid confusion, only the acronym UM is used in this text, and care management is not used at all because it has the same acronym as case management.

The overall cost of health care is calculated as the result of two variables: price multiplied by volume. Previously, Chapter 4 addressed the challenge of managing the first variable, price, by adopting various payment methodologies. Recall that some payment methodologies incorporate utilization goals into how they are applied; for example, capitated risk pools, or value-based payment that includes utilization measures. In the absence of such payment approaches, payment can be an incentive for increased utilization.

In this chapter, we look at means to manage the other variable, volume, through UM. We also consider four related types of specialized UM that focus on high cost and/or medical conditions—namely, case management (CM), disease management (DM), transition management, and Patient-Centered Medical Home (PCMH).

Quality management (QM) is also a focus for payers. Several other terms may be used as alternatives to QM, such as quality assurance (QA) and quality improvement (QI); some sources also use the word total, as in total quality management (TQM).* For our purposes, they all essentially mean the same thing. Thus, to avoid confusion, only the acronym QM is used in this text.

Accreditation programs assess a payer's policies, procedures, and performance in multiple areas, with much of that assessment being focused on UM, CM, DM, and QM, as well as network management, member services, and other member-centric functions. The heavy emphasis placed on UM, CM, DM, and QM in accreditation is the reason it is addressed in this chapter.

For UM, QM, and accreditation purposes, the privacy requirements established in the Health Insurance Portability and Accountability Act and various state privacy laws set limitations on access to medical and personal health information. Because of this, a payer may access only the medical records and information for individuals who are or were members during the period being examined.

The functions described in this chapter are usually part of payers' core operations, but some health plans, including some self-funded plans, contract with an external company to perform all or some of them. Also, some plans, usually but not always self-funded plans, do not perform everything discussed in the chapter. On the other hand, HMOs are likely to place more focus and attention on the activities described in this chapter than are non-HMO payers.

A provision of the Affordable Care Act (ACA) of 2010 places limits on the medical loss ratio (MLR) for all insured businesses. This MLR limit means the total percentage of the premium that must be spent for medical benefits and not operations, sales, governance, profit, and so forth. Under the ACA, the costs of providing wellness and prevention and the costs to perform QM are usually not considered to be administrative costs; in contrast, the costs to perform UM, CM, and DM, as well as credentialing and network management, are considered administrative costs and are included in the MLR limits. This is the case even when it is delegated to a provider

* Some payers have also adopted the use of six sigma, but that level of detail is not necessary for a discussion of QM by payers.

organization such as an independent practice association (IPA) or medical group.

Prevention and Wellness

Preventive health care spans both the management of utilization and of quality. Dr. Paul Elwood coined the term health maintenance organization in the 1970s to highlight the idea that HMOs provided preventive services and maintained health. At the time, preventive services were not covered by most health insurers, and it was many years before coverage of prevention became the norm. Under the ACA, first-dollar coverage of preventive services became mandatory, meaning no cost sharing is allowed when such services are provided by network providers, regardless of any other required cost sharing.

Prevention is aimed at preventing certain diseases or conditions or preventing existing conditions from worsening. Childhood screening and immunizations are the most obvious examples of prevention, but it includes other services too such as adult immunizations, Pap smears, mammography, and screening for high cholesterol, high blood pressure, diabetes, and other common chronic diseases. Wellness programs are another form of prevention and are directed at helping members to change their lifestyles and develop healthy habits—for example, weight loss, smoking cessation, and exercise programs.

Health risk appraisals (HRAs) are a self-administered assessment tool used to quickly make an overall assessment of a person's medical risk factors. Many or most payers have automated HRAs on their websites that also provide feedback, serving to encourage a member to make better health choices. Examples of such feedback might include the value in potential added life-years from losing weight, stopping smoking, or having routine screening tests done.

Different types of HRAs may be focused on specific groups of members, such as commercial, Medicare, or managed Medicaid members. Some advanced Medicare Advantage (MA) plans go beyond data-gathering forms and reminders about physical exams, and ask permission to send a nurse, clinical social worker, or home aide to the residence of a new Medicare member. Once there, they may do a nutritional assessment, check for compliance with prescribed medications, and look for simple interventions that could prevent problems later, such as providing an inexpensive bathmat to reduce the member's risk from slipping in the tub and breaking a hip.

Measuring Utilization

Many different types of measurements or metrics are used when managing utilization and the cost of medical services. Most payers use metrics based on a standard set of calculations; depending on the type of payer, those measures may be refined even more. The most commonly used ones are described in this section.

As an informal rule of thumb, metrics are calculated so the results will have at least one and no more than four or five integers, meaning numbers to the left of the decimal point. This makes them more useful as management tools. To achieve this, some metrics are based on a year and others based on a month or a day, and some metrics use an average per thousand members and others use an average per member. Metrics are also generally standardized so useful comparisons are possible. Examples of how this is done are also described in this section.

In health insurance and managed care, many metrics are given on a per-member per-year (PMPY) or per-member per-month (PMPM) basis. These metrics refer to the average number of times something happens or the average cost of something, spread across the entire membership over the course of a year or a month respectively. As an example of PMPY, a typical commercial (non-Medicare/Medicaid) HMO may report physician encounters or office visits as being 4.5 visits PMPY, meaning

that, on average, members saw a physician 4.5 times per year. Obviously, some members saw a physician more often, whereas other members saw a physician less often.

Some measurements are completely straightforward; for example, the average length of stay (ALOS, or just LOS) is just what it sounds like for inpatient hospital stays. It is also common to measure utilization and/or cost on a PMPM basis, meaning that the total utilization and cost for all of that type of service during a month is divided by the total number of members in the plan that same month, regardless of whether each member received care (and most do not). A hypothetical example is shown in **TABLE 5.1** for a commercial HMO, using the following assumptions:

- The HMO has 100,000 members.
- On average, 7,000 outpatient procedures are performed on the HMO's members in a month.
- The average cost per outpatient procedure paid by the HMO is $1,500.00 (procedure costs vary widely, even for the same procedure, so the average cost is used in this example).

A form of measurement that is useful for utilization of facility-related care is per 1000 members per year; that is, instead of the average based on each member, the data are averaged based on every 1000 members over the course of one year. Per-thousand metrics are most often used for inpatient bed-days, inpatient admissions, and ambulatory procedures; an example is bed days per 1000 (sometimes abbreviated as BD/K). Utilization per thousand is an annualized metric, meaning it is calculated based on a year. For example, an admission rate of 55 admissions per thousand means that an average of 55 out of every 1000 plan members are admitted during the course of a year. But while per-thousand metrics are calculated on an annualized basis, they may be calculated for any period of time.

The standard formula to calculate utilization per thousand is relatively straightforward and will be illustrated by looking at bed-days per thousand. The exact same formula is applicable to calculating admissions and ambulatory procedures per thousand. It may be calculated for any chosen period (e.g., a single day, month to date, a quarter, or year to date). Because the measure is always annualized, the calculation of bed-days per thousand uses the assumption of a 365-day year as opposed to a 12-month year to prevent variations that are due solely to the length of a month. The formula is $(A \div (B \div 365)) \div (C \div 1000)$, where:

- A is the gross (meaning the total) number of bed-days (or admissions or ambulatory procedures) in the time period

TABLE 5.1 Example of Hypothetical Outpatient Procedure PMPM Cost Calculation

Total membership in the month	100,000
Total number of outpatient procedures in the month	7,000
Average cost per outpatient procedure that month	$1,500.00
Total gross cost of outpatient procedures that month	$10,500,000.00
Total month's whole-dollar cost is divided by total membership to calculate the PMPM cost	$105.00 PMPM

- B is the total number of days in the time period being measured, such as:
  - a single day
  - number of days, month to date
  - number of days in a month
  - number of days, year to date
  - 365 days (i.e., one year)
- C is the average plan membership in the period being measured

This calculation may be broken into steps. **TABLE 5.2** illustrates the calculation for bed-days per thousand using two separate periods of time.

Medical Necessity and Benefits Coverage Determinations

The fundamental role of any payer is to manage healthcare benefits coverage. In practical terms, that means determining what will and will not be covered and under which circumstances. Coverage decisions are not the same as medical care decisions made by a doctor and a patient. Managed healthcare plans make only coverage decisions. They do not actually provide the care, prevent it from being provided, or prevent it from being sought out by the member. A statement like "My HMO would not allow my doctor to [perform a specific procedure]," really means the HMO would not authorize coverage or payment for it, and not that the HMO has the power to order doctors around. This is not to say that denial of coverage cannot create a substantial barrier to costly medical services—it does, though not an absolute one. Some people do pay for their care out of their own pockets; costly cosmetic plastic surgery is a common example.

Medical Necessity

Medical necessity and medically necessary are broad terms used by payers for a very specific purpose as part of the process for benefits

TABLE 5.2 Example Calculations of Bed-Days per Thousand (BD/K)

Calculation of BD/K for a Single Day	Calculation of BD/K for Three Weeks into the Month to Date (MTD)
Assume: ■ Current hospital census: 300 ■ Plan membership: 500,000 ■ Days being measured: 1	Assume: ■ Total gross hospital bed-days: 6,382 ■ Plan membership: 500,000 ■ Days so far in MTD: 21
Step 1: Gross days 300 ÷ (1 ÷ 365) = 300 ÷ 0.00274 = 109,500	Step 1: Gross days 6,382 ÷ (21 ÷ 365) = 6,382 ÷ 0.0575 = 110,925.24
Step 2: Days per 1,000 109,500 ÷ (500,000 ÷ 1,000) = 109,500 ÷ 500 = 219 (rounded)	Step 2: Days per 1,000 110,925.24 ÷ (500,000 ÷ 1,000) = 110,925.24 ÷ 500 = 222 (rounded)
Result: The BD/K for the single day is 219.	Result: The MTD BD/K is 222.

coverage determinations, and both terms mean the same thing. Medical necessity is a factor in coverage determinations when medical goods or services may or may not be covered depending on certain criteria.

Medical necessity as used by payers is often difficult for members and providers to understand. A provider or member may consider a medical service to be necessary, yet that service may not be considered medically necessary as applied to benefits coverage. This conflict arises because the service must still meet the definitions, limitations, exclusions, and coverage requirements of a health benefits plan. And although the medical necessity policies of most payers are similar, they are not identical; and for insured (not self-funded) coverage policies, state mandated benefits laws (see Chapter 8) may also be a factor.

As noted above, the specific wording used to define medical necessity often varies somewhat from plan to plan, but its meaning is similar in most plans. Medical necessity in commercial health benefits plans is typically defined by broadly describing the medical goods or services that may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Medical necessity definitions also typically describe the types of services that are excluded from coverage because they are not considered to be medically necessary. Some examples of excluded types of services are:

- Services that are primarily for the convenience of the patient or physician
- Services that are costlier than an alternative service or sequence of services at least as likely to produce equivalent results
- Custodial care or care that is essentially assistance with acts of daily living
- Experimental or investigational care, except in defined circumstances
- Care not considered medically appropriate by generally accepted standards of medical practice

Some the coverage exclusions on this list also mean that some medical services, drugs, or devices may be covered for one member but not another depending on each member's specific clinical circumstances as determined using evidence-based clinical guidelines. In some cases, it is more a matter of providing the proper clinical information to the health plan than it is not meeting clinical criteria. In other cases, something may not be covered simply because a less expensive alternative has not been tried, but it may be covered if the less costly alternative does not work, or work well enough, or cannot be tolerated.

Use of Evidence-Based Clinical Guidelines for Coverage Determinations Based on Medical Necessity

Coverage decisions involving medical necessity are made with input from many possible sources, but the primary source is typically the treating physician and/or PCP. For example, a treating physician may be asked to provide clinical justification about why a very costly test is being requested when a less costly test will provide much of the same information. In some cases, however, UM managers and medical directors will also review cases based on condition-specific medical necessity coverage guidelines.

Medical necessity coverage guidelines are not arbitrary, and typically rely on evidence-based medical guidelines that take precedence over differing community-based practice standards or even the opinion of the treating physician. Payers do so because of several limitations associated with physician practice behaviors; for example:

- Physicians cannot easily keep up with all changes in medical knowledge.
- There are significant regional variations in physician practice behavior that are unrelated to clinical conditions.

- There is a lack of consistency in adopting evidence-based medical practices.
- Some physician practice behaviors are habits, not medical judgment, and often change over time as a result of payment policies.
- Some physicians will adopt medical interventions not yet shown to be effective through randomized controlled medical studies.

Evidence-based clinical criteria and guidelines are based on formal medical studies and clinical trials that compare different approaches to care, with their results being published in peer-reviewed medical journals.* Some guidelines may be absolute—for example, no coverage for experimental or investigational treatments administered outside of a qualified research institution, or no coverage for a procedure that has been shown to not b3 effective. Many (even most) other guidelines are relative, meaning they consider an individual patient's medical condition as supported by medical records. For example, an insulin infusion pump may not be covered if a member with diabetes is able to achieve good blood glucose control with one or two insulin injections per day, but it will be covered if the member cannot achieve good control according to specific clinical criteria.

Larger payers may have internal working groups that create the evidence-based clinical guidelines and change them as medical science advances. Many payers license guidelines from vendors such as MCG's Evidence-Based Care Guidelines® or Change Health's InterQual®†, that they can load into their computer systems to use for UM and claims processing. Licensing evidence-based clinical guidelines is an efficient way for payers to have access to a wide array of guidelines that have been developed using verifiable methods, and to have those guidelines regularly updated, which a mid-sized payer may not be able to do. Hospitals may likewise license these guidelines for their own internal UM programs. Payers typically make their evidence-based clinical guidelines accessible to their network providers and members, and sometimes to the general public too.

The Centers for Medicare & Medicaid Services (CMS), the federal agency in charge of Medicare, also has extensive guidelines its intermediaries use for coverage determinations in the traditional Medicare program; and state Medicaid agencies typically use those as well. Another source is the Cochrane Review and Library.‡ The Agency for Healthcare Research and Quality (AHRQ), a federal agency related to CMS, used to provide access to a wealth of evidence-based clinical studies through its National Guideline Clearinghouse (NGC), but AHRQ's budget was cut in 2016 and the NGC was shut down in July 2018 when funding ran out.

Basic Utilization Management

Basic UM usually refers to the routine functions used to manage through coverage determinations the amount and types of medical services provided to members, and to manage costs in combination to provider payment policies (Chapter 4). Basic UM is usually carried out by the payer, but as noted earlier it may also be delegated to an IPA or medical group, or in some cases to a contracted medical management company.

* Not all types of medical studies are definitive. The most definitive are randomized trials that compare two options head to head on equal footing. The least definitive are cohort and case studies.

† Formerly a subsidiary of Milliman, MCG Evidence-Based Care Guidelines is now a subsidiary of Hearst Health. Formerly a subsidiary of McKesson, InterQual is now owned by Change Health. The author has no relationship with either company.

‡ Cochrane is a nonprofit organization funded primarily by the U.S. National Institute for Health Research and the U.S. National Institutes of Health.

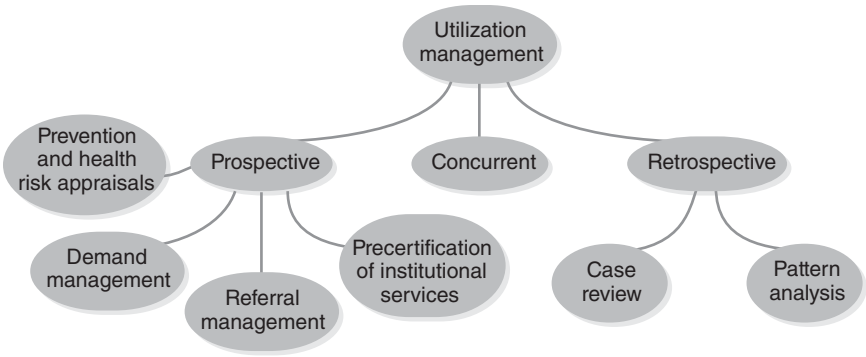

FIGURE 5.1 Basic Components of Utilization Management

Basic UM, which is considered distinct from DM and CM, encompasses prospective, concurrent, and retrospective review as seen in **FIGURE 5.1**. Prospective review addresses utilization before it occurs. Concurrent review addresses utilization as it occurs. Retrospective review, which usually takes place after the fact though it can sometimes be done while care is still being provided, includes reviewing utilization patterns or specific cases. This section looks at UM that may apply to physician and facility services only, but it may also be applied to managing utilization of ancillary services and prescription drugs as discussed later in the chapter.

Emergency Services

Before continuing, it is worth noting that most forms of UM are not used in the case of emergency services because the ACA requires all payers to cover emergency care without preauthorization, at an in-network level of benefits, if it meets a prudent layperson standard. The ACA defines this as a "…medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition [placing the health of the individual (or unborn child) in serious jeopardy; that would result in a serious impairment to bodily functions and/or a serious dysfunction of any bodily organ or part.]"* States may define the prudent layperson standard even more loosely (for insured business), but not less.

Payers may not use their own definition of prudent layperson, but they still make determinations of reasonableness. To do so they use retrospective utilization as described below, and if a payer determines that a member sought out and received emergency care for problems that were not emergencies under the definition, they may deny or reduce coverage. Some payers also contract with medical groups or companies that have emergency physicians on staff that can take over a case in an emergency department as a form of case management.

Prospective Utilization Management

Prospective UM includes demand management, referral management, and precertification of costly or facility-based elective medical goods or services. Some include prevention in this category as well, a topic we looked at earlier.

* 29 CFR § 2590.715-2719A(b)(4)(ii). The definition quoted in this chapter has been abridged to whittle out excess language and to include language that is only cross-referenced in the actual law.

Demand Management

Demand management is intended to influence the future demand for medical services but differs from prevention in its focus on acute or near-term care. The most common demand management methods include providing a round-the-clock nurse advice line so that members can access a trained nurse, 24 hours a day, 7 days a week by calling a toll-free number. The advice lines rely heavily on clinical protocols. Many payers that have advice lines have seen a decline in emergency department utilization.

Another form of demand management is the retail clinic. These clinics are usually staffed by clinical nurse practitioners and are often operated by large national companies such as a retail pharmacy chain, and most payers contract with at least some of them. Retail clinics focus on common minor medical problems such as a sore throat or urinary tract infection, as well preventive services such as immunizations.

A more elevated type of demand management is telemedicine, or telehealth, which refers to a licensed physician that a member may consult through a secure video link from their home computer, or an app on a mobile device. Most payers cover telemedicine, and usually contract with a single telemedicine service provider. Because the telemedicine physician is typically licensed in the state in which the patient is when they access the service, the physicians can call in a prescription if necessary.

Both retail clinics and telemedicine usually have lower out-of-pocket cost-sharing by members compared to an emergency room or an in-office physician visit, and charges to payers are lower as well. Unfortunately, it appears that they do not save money in the long run and may even increase utilization overall. Even so, many payers continue to contract with telehealth providers to provide members with convenient access to address minor problems.

Referral Management

Referral management, sometimes called referral authorization or preauthorization, is principally confined to HMOs (and POS plans for their highest coverage levels) that use a PCP gatekeeper model. In this model, a member's PCP determines which medical services are truly necessary, coordinates the provision of these services, and thereby reduces unnecessary utilization. The provision of care by any healthcare professional other than the PCP must be authorized by the PCP.

An authorization requirement allows the PCP to determine if a health problem or condition requires treatment by a specialist. If it does, the PCP authorizes a referral to a network specialist. Referral authorization is usually not open ended, but instead authorizes a specific number of visits (e.g., one to three), an episode of care (e.g., surgery), or a course of treatment (e.g., the entire course of chemotherapy treatment).

The ACA requires all types of payers to allow direct access to obstetricians/gynecologists (OB/GYNs), including gatekeeper-type HMOs, though this had long been the practice of most HMOs even prior to the ACA's enactment. However, HMOs vary as to whether an OB/GYN may also authorize a referral to another specialist, and most also require a female to also have a non-OB/GYN PCP. Many HMOs also allow direct access to providers specializing in behavioral health or substance abuse care.

It is rare for an HMO (or IPA when UM is delegated) to become involved in a PCP's referral authorization process other than to capture the authorization data to process the claim properly. The PCP is expected to exercise proper clinical judgment without the HMO's intervention. The HMO typically provides the PCP with periodic reports containing data on referral rates and costs, as well as reports on the PCP's capitation pool or withhold if that is appropriate (see Chapter 4). Plan policies for coverage determinations are also available.

Finally, referral management may also apply to PPOs when a member or a member's physician seeks in-network level of coverage of a referral to a non-network specialist because there is no equivalent specialist in the network, or because of the member's unique clinical needs.

Precertification of Institutional Services

Prospective management of institutional services, both inpatient and outpatient, and for coverage of certain devices and drugs, is a staple of almost all types of payers. It is usually referred to as precertification, preauthorization, or prior authorization. The process is usually simple: A nurse or a similar clinical support person in a physician's office contacts the payer to request authorization for an elective admission or outpatient procedure, the payer checks the request against clinical criteria and determines whether the facility is in the contracted network, and the payer either does or does not authorize coverage of the procedure. In the case of an inpatient admission, the payer usually assigns an expected length of stay as well. A precertified service is also issued a unique number or code to use on admission and for billing. The facility where the procedure is to be performed typically also checks the precertification status before services are provided.

Most precertifications are obtained by a provider or a provider's office staff calling the payer, but an increasing number are being done electronically through a provider portal. Calls may be routed through an automated voice response system that collects the required information, or calls may be answered by clinical support personnel. In cases where precertification is denied, the provider will have an option to talk live with a plan representative.

Electronic precertification is frequently done through clinical checklists or algorithms, and the clinical criteria are usually the same medical necessity policies described earlier. Access to clinical guidelines is usually included. Most payers now use computerized programs that enable them to determine quickly whether the clinical criteria are met and to capture pertinent data. The same precertification algorithms are used for both provider self-service and for precertification personnel at the plan. If criteria are met, an authorization is usually issued along with the standard maximum allowable LOS.

In indemnity insurance plans or to access the out-of-network benefits in PPOs and POS plans, failure to obtain precertification results in the member facing higher levels of cost-sharing compared to the in-network level. Non-network providers often, but not always, obtain precertification on behalf of their patient even though they are not contractually required to do so, but the final responsibility is the member's, not the non-network provider.

For any coverage in HMOs and to be covered at the in-network benefits level in POS plans and most PPOs, the burden of responsibility falls on the network provider, and it is the provider who faces an economic penalty for failure to comply with precertification requirements. Contracts between payers and providers also frequently contain provisions requiring the facility to verify authorization as well to avoid a payment penalty. The type of financial penalty can vary from a coverage reduction for PPOs to denial of payment by HMOs.

Concurrent Utilization Management

Concurrent UM refers to UM activities performed during a course of treatment, not before or after. It is used primarily for hospital inpatient care, where it is sometimes called continued stay review. Concurrent UM may also be used for certain types of long-term outpatient care such as an extensive period of physical therapy, or for behavioral healthcare treatments.

As with all basic UM, concurrent review is performed for purposes of benefits determinations, not to interfere directly with care. If the hospital stay may exceed the number of previously authorized days, the UM nurse

will collect clinical data and compare them to clinical guidelines for the condition or procedure, thereby determining whether the case meets the criteria for continued coverage. The reviewer then either authorizes the additional days or denies coverage for them. Rather than deny coverage outright, however, the UM nurse is just as likely to work with the attending physician or hospitalist and the hospital's own UR and discharge planning department to obtain any necessary additional documentation and to help facilitate the patient's discharge.

Payers with many hospitals in their network often perform concurrent review via telephone, working through hospitals' UM nurses to find out the status of cases. HMOs that more actively manage utilization will often send UM nurses to high-volume network hospitals to obtain more detailed and timely information and be more actively involved with discharge planning. The process is otherwise the same as just described, but communications and information exchange are better than when only the telephone is used. Because so much inpatient care now involves hospitalists, they are also typically involved in the process.

When UM nurses determine that continued stay criteria have not been met for a case, but the attending physician disagrees, the UM nurses rarely confront the attending physician directly. Instead, they refer such cases to a medical director. The medical director may call the attending physician to discuss the case, and then determine if continued coverage is warranted. If the medical director denies continued coverage authorization, the denial may be appealed, as described briefly in this chapter and in more detail in Chapter 6.

Discharge Planning

Discharge planning is a function of concurrent UM, but it can also be an important element of case management. Routine discharge planning involves working with a hospital's discharge planning department to facilitate discharge by arranging follow-up services such as physical therapy, scheduling follow-up appointments, and so forth. It is also common to contact a recently discharged patient to see how well the individual is doing, including asking the patient specific questions related to any procedures and answering any questions the newly discharged patient or his or her family may have.

Transition management is a combination of discharge planning and case management, and both are addressed a bit later in the chapter.

Retrospective Utilization Management

Retrospective UM refers to UM or UM-related activities that take place after care has been provided. Retrospective UM can be classified into two broad categories: case review and pattern analysis.

Case Review

In case review, past cases are examined for appropriateness of care, billing errors, or other problems. If an error or irregularity is found, the payer may adjust payment or at least investigate the case. Case review also may occur if a member seeks coverage after services have been provided without prior authorization or precertification, in which case it may also be related to the appeals process.

Pattern Analysis

Pattern analysis involves using utilization and claims data to determine whether patterns exist. This is no easy task because the number of billing codes is massive.* As a result, the scope of claims data is also massive, so computers are required to perform this analysis. Those computers, however, must be told what

* A rough estimate is over 100,000 codes, including codes used by each of the many contracted professionals, facilities, ancillary services, pharmacies, and other types of providers and vendors of healthcare goods and services.

to look for and which data to use. A payer cannot simply dump all claims data into an analytic system and hope the computer can figure out what to analyze. There is usually some triggering event or larger trend that provides a focus or direction for a payer to program the analytics system.* Examples include learning of a possible problem through another party or seeing a rise in the overall expected costs for a costly service.

Identified patterns usually end up being provider specific; for example, a physician or medical group may have an abnormally high procedure rate such as cardiac testing performed in the physician's office. After a pattern is identified, the reasons underlying it must be investigated to identify if corrective actions need to be taken.

Payers often seek to improve how they share retrospective data with the network providers to allow the providers to compare themselves with their peers and modify their own practices as appropriate. Such an element may be part of a pay-for-performance program, for instance. It is also used in data transparency programs in which payers provide comparative data about healthcare cost and quality to members.

Appeals of Coverage Denials

A payer's determination to deny coverage for something is not necessarily locked in. Even prior to the ACA, almost all payers were required to provide a mechanism for members to appeal a denial of coverage, whether it was before services were received (preauthorization or precertification) or after services were provided but were then not paid for by the payer. The ACA made these requirements standard for all types of payers.

An informal review means that a member, family member, and/or a member's provider gives the payer additional information and the payer's UM personnel take it into account. There are also two formal types of appeal reviews that must be undertaken in a defined amount of time after a member requests them:

- *Internal Rereview*: Physicians in the same or a related specialty, and who work or consult with the health plan but who were not involved in the initial denial decision, review relevant material and either uphold the denial or overturn it. An overturned denial is binding on the plan.
- *External Review*: State-approved third-party physicians in the same or a related specialty that have no affiliation with the plan review the case and either uphold or overturn the denial. An overturned denial is binding on the plan.

Appeals of coverage denials is described more fully in Chapter 6 and noted here only to point out that an initial coverage denial is not always the last word.

Disease Management, Case Management, Transition Management, and Patient-Centered Medical Home

Although most plan members have routine medical needs, some have serious chronic medical conditions—for example, severe diabetes, chronic obstructive pulmonary disease (COPD), or certain heart conditions—that

* The common exception to this is large-scale fraud detection, which uses confidential program logic to look for patterns indicating possible fraudulent billing. It is discussed in Chapter 6.

require ongoing medical care to reduce the risk of worsening. Likewise, certain acute cases—for example, an individual who is involved in a severe automobile crash or a very premature newborn—are expensive but are usually episodes that eventually resolve, though it may take some time. In fact, about 5% of individuals account for approximately one half of all healthcare costs, regardless of being covered by commercial health plans, Medicare, or Medicaid. Payers address this issue of concentrated costs through several related types of programs: CM, DM, PCMH, and Transition Management. The intent of all of them is to help reduce the member's risk of developing complications and deteriorating, help improve outcomes and quality, and manage costs. CM and DM are described next, followed by the other two.

Case Management and Disease Management

CM and DM are the most common programs seen in payers, and though similar they have differences and are not mutually exclusive. Some distinctions between DM and CM are shown in **TABLE 5.3**.

Almost all payers have a CM program, which is also sometimes called a large case or (if very costly) a catastrophic case* management program. Most, but not all, also have a DM program. Many self-funded plans, because they pay separate fees for each type of service, usually contract for CM, but are less likely to include DM. Both DM and CM are typically performed using computerized decisions support systems and databases.

The larger payers typically have their own CM and DM programs. But many mid-sized and smaller payers contract with external companies to conduct their DM activities because a large DM company is better able to stay current with advances in treatment options and make the necessary investments in information technology to support these specialized clinical functions. Except for self-funded plans, it is less common for payers to outsource CM, but that occurs as well.

CM of catastrophic or high cost cases, in which costs often exceed routine costs by several orders of magnitude, have the potential to deliver substantial savings under CM. Specially trained CM nurses coordinate aspects of care such as rehabilitation, home care, health education, and the like, thereby improving outcomes and reducing expenses. Table 5.3 listed attributes of CM that differ from DM, but we must add one more: CM may work with members who have a chronic condition that is not part of their DM program. For example, there are few DM programs that address cancer care, and while some treatments for cancer do not benefit from CM, there are others that do.

DM has similarities to CM but it focuses on a handful of selected conditions, working proactively with each patient to manage the course of the disease and to avoid hospitalizations that can occur when there is a deterioration in the person's condition. The usual result is greater continuity, lower overall costs, and better outcomes compared to unmanaged cases. What sets DM programs apart is their focus on specific common chronic conditions such as diabetes and heart disease—conditions that are both widespread and that can see a significant benefit from behavioral changes and self-care.

Said another way, DM programs use many different approaches intended to improve outcomes, or at least slow down the effects and complications associated with those conditions. This is accomplished not only through

* Other terms sometimes used by reinsurers, insurance companies, and actuaries for the costliest cases under CM include the slang terms: "Cat Case," which is short for Catastrophic Case; and/or "Shock Claim" as a metaphor for a high cost claim that shocks the financial reserves used for claims payment.

TABLE 5.3 Differences Between Case Management and Disease Management

Traditional Case Management	Disease Management
Emphasis is on individual patients	Emphasis is on individuals in a population with a chronic illness
Early identification of people with acute catastrophic conditions with known high costs or diagnoses known to lead to high costs in the near term	Early identification of all people with targeted chronic diseases whether mild, moderate, or severe
Acuity level of catastrophic cases is high; acuity level of traditional cases is high to moderate	Acuity level is usually moderate
Applies to approximately 0.5%–1% of commercial membership	Applies to approximately 15%–25% of commercial membership (slightly higher for MA members)
Value relies heavily on price negotiations and benefit flexing, and often community resources as well	Value stems from member and provider behavior change that results in improved health status
May require plan benefit design manipulation (e.g., adding more home care visits)	May requires plan benefit design changes that reward enrollment in DM and shrink some drug copayments
Primary objective is to arrange for ongoing care during episode, using the least restrictive, clinically appropriate alternatives	Primary objective is to avoid hospitalization and modify risk factors, lifestyle, and medication adherence to improve health status
Typical episode is 60–90 days	Intervention is 365 days for most conditions
Site of interaction is primary hospital, hospice, subacute facility, or health and home care	Site of interaction includes work, school, home, and physician office
Driven by need for arrangement of support services, community resources, transportation	Driven by nonadherence to medical regimens
Outcome metrics is LOS for a single admission, and total cost per case	Outcome metrics are annual cost per diseased member and disease-specific functional status and gaps in care

more intense monitoring, but also by improving patients' ability to care for themselves by improving medication compliance, instilling better eating and exercise habits, promoting self-monitoring, and facilitating greater understanding of their own medical problems.

A hallmark of a DM program is the inclusion of numerous types of health professionals, not just physicians. For example, a clinical pharmacist may play a more active role in managing childhood asthma than the pediatrician by teaching the child how to use inhaled steroids.

Likewise, a dietitian may be of great service to patients with a severe heart condition or diabetes by helping them learn how to maintain a good diet and avoid unhealthy habits.

DM and traditional CM programs must have multiple ways of identifying which members might be good candidates. Individuals with clinical conditions who would benefit from greater interventions are often identified by nurses or hospitals during concurrent utilization review, for example. Most DM programs also use specialized computer programs that analyze medical and drug benefit claims for diagnoses and for the types of drugs being prescribed, through HRAs, or through sophisticated data modeling programs that seek to predict which members may be deteriorating clinically. In addition to identifying these members, it is important to determine which level of intervention would be most appropriate. This process is illustrated in **FIGURE 5.2**. Most DM programs also use outreach that is similar to that described earlier under Demand Management but more proactive.

Members with multiple chronic conditions, meaning two or more serious chronic conditions at the same time, require even more medical care and incur even higher costs. Individuals with multiple chronic conditions usually also see multiple specialists, and unfortunately their care is often not well coordinated between them. In a sense, the person with multiple chronic conditions can easily become the ball in a game of medical pinball, bouncing or bumping from one type of specialist to the next.

A particular difficult problem for individuals with multiple chronic conditions is that they are often prescribed different drugs by different doctors, some of which may duplicate what another prescribed drug is doing or have a negative drug–drug interaction. Making this worse is the sheer number of prescribed drugs these individuals are on—each with an unpronounceable name—that are easy to forget or mix up.

The most effective DM programs use many of the specific methods noted above to identify and address the needs of those with multiple chronic conditions, but some DM programs function as silos, where each protocol focuses on only one type of disease, and they may not be as effective.

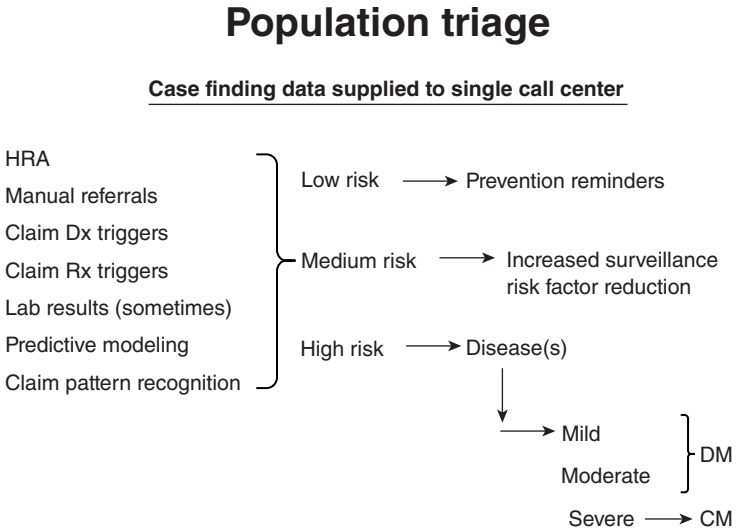

FIGURE 5.2 Identification of Candidates for Case Management or Disease Management

Modified from Best Practices in Medical Management; Aspen Publishing, Kongstvedt P and Plocher D editors, 1998. © Peter R. Kongstvedt, used with permission.

Patient-Centered Medical Home

PCMH, sometimes called simply medical home, is intended to be a comprehensive type of program meant to increase care coordination for those with multiple chronic medical conditions. PCMH usually includes elements from DM and CM but is broader. It also often includes transition management as described below, but it is not confined to post-discharge patients. PCMHs may be a form of IDS (see Chapter 3), but a PCMH may also be a physician-only entity, a joint payer–provider activity, or used by a payer alone.

Accreditation organizations that are described later in the chapter have recognition programs for PCMH, but not outright accreditation, at least as of the time of publication. There is no defined organizational structure or single payment methodology for PCMH, and it does not require state licensure. It is more a set of concepts and practices. For that reason, it is more appropriate to discuss it in this section rather than the section in Chapter 3 on IDSs.

PCMH was conceived by the leading PCP organizations as a set of attributes or components, calling it Primary Care Medical Home. In this original concept, a patient's PCP served to coordinate all of a patient's care, like the original group and staff model HMOs but without a gatekeeper requirement. Although some may still refer to PCMHs as Primary Care Medical Home, the acronym PCMH now stands for Patient-Centered Medical Home, a change in terminology that reflects the shift in focus to the patient rather than having an additional focus on PCPs, and the inclusion of a broader range of medical personnel and approaches.

Currently, most PCMHs rely on an organized team of providers. These teams may be led by physicians, but more often the physicians are team members, with the teams being led or coordinated by other clinicians. Non-physician team members often include providers such as clinical nurse practitioners, physician assistant, pharmacists, and medical social workers.

Payer contracts with PCMHs usually do not supersede existing network contracts or replace any parts of the network, but rather add to the ongoing system. PCMH contracts may be limited to PCPs in some markets, but more often the contracts are reached with IDSs. Contracts with PCMHs often use VBP models as discussed in Chapter 4, that support the twin goals of improved outcomes and lower costs. Some payers contract with medical groups and pay them a small monthly management fee to take on this function, and those groups may or may not use the broad approach described here. In other cases, there is little or no financial reward, and many medical groups end up seeing a decline in revenue, though that may change over time. There is no consistency at present.

CMS gave PCMHs a boost prior to passage of the ACA through pilot programs designed to see if these models could be successfully applied to traditional FFS Medicare. The ACA boosted their profile even more by addressing PCMHs directly,* including allowing those that meet state fiscal and licensure requirements to offer coverage directly through the health insurance exchanges, meaning they must meet all applicable state requirements for health insurers or HMOs.†

Like ACOs, studies showing positive results from the adoption of PCMH come mostly from IDSs and medical groups that were already experienced in providing cost-effective care. Most studies also do not include the full cost of operating a PCMH, so it is not clear if they save money overall. There is some evidence that they may improve service and outcomes, but not overall utilization.

CMS gave a boost to a similar program, the Comprehensive Primary Care Initiative

* The ACA refers to them as "Primary Care," not "Patient Centered" Medical Homes in section 1301 [42 U.S.C. 18021].
† The ACA does not explain why this provision is included when it does nothing.

(CPC), providing additional support to hundreds of PCP practices in the United States with a goal of improving primary care delivery, quality of care, and reducing spending. It succeeded in the improving access, providing better transition management and other care management, and slightly reducing use of the emergency room by individuals with complex conditions. It did not, however, lower costs enough to offset the additional care management fees paid to the PCPs that resulted in higher total costs, or change the overall experience of beneficiaries in the traditional FFS Medicare program. But PCMH and programs like CPC are still relatively new and may yet meet their goals.

Transition Management

Transition management, which may also be called Care Coordination and Transition Management (CCTM*), is a term for a focused combination of discharge planning and CM that is primarily aimed at preventing avoidable readmissions by patients newly discharged from a hospital.

Avoidable readmissions were described in Chapter 4, and the associated potential payment penalties was a strong motive for hospitals and IDSs to develop these more intense types of discharge planning and follow-up CM programs. Transition management focuses specifically on managing the transition from inpatient to outpatient for patients with multiple chronic medical problems. A hallmark of transition management is the focus on communications between the physicians and hospital where the person was admitted, and the physician(s) they see as outpatients (who are usually not the same).

The same techniques, though not always the same term, are also used by accountable care organizations (ACOs) in traditional FFS Medicare, many ACOs and IDSs with commercial payer contracts that are under VBP, and by PCMHs. Just as with PCMH, these programs use multi-disciplinary teams that stay actively engaged with individuals at risk of complications from chronic conditions that could land them back in the hospital.

Utilization Management of Ancillary Services

Recall from Chapters 3 and 4 that ancillary services are broadly divided into two major categories and two smaller ones. One major category is diagnostic services, such as laboratory testing, electroencephalography, cardiac testing, and imaging studies such as radiology, nuclear testing, computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), and so forth. The other major category is therapeutic services, such as physical or occupational therapy, rehabilitation, and the like. The two smaller categories are medical transportation, including ambulance and scheduled medical transportation; and custodial care that is covered only by Medicaid for individuals that qualify. Excluding emergency ambulance services, ancillary services must be ordered by a physician.†

Managing Utilization of Ancillary Services

There are several components for managing utilization of ancillary services (**FIGURE 5.3**), and they are not in any sequence or order. Payers may not even use all approaches described here

* CCTM is sometimes used as the acronym for transition management, but TM is not, perhaps because that acronym can also stand for Trade Mark or Transcendental Meditation®. But it's a free country so you can call it what you like.

† Some medical testing companies offer to the public certain tests that do not require a doctor's order—for example whole-body scans or DNA testing—but health plans do not cover them.

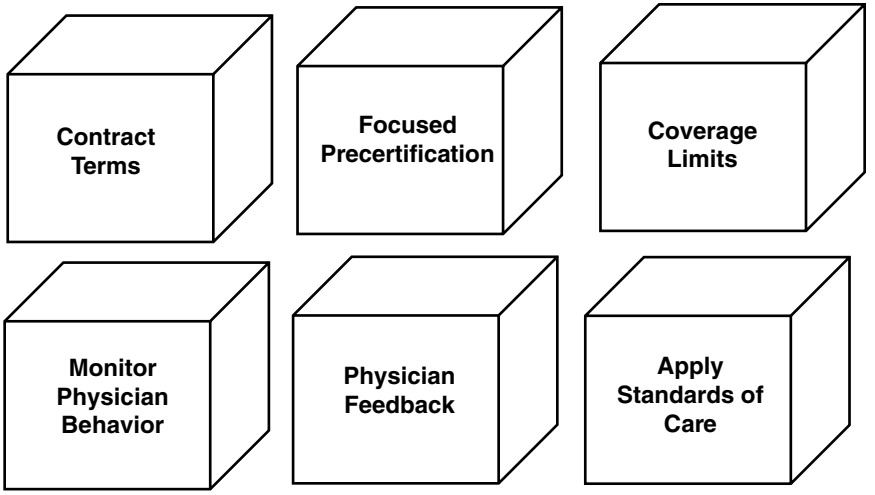

FIGURE 5.3 Components for Managing Utilization of Ancillary Services

and may apply them on a focused basis depending on where higher than expected costs are being incurred. Note that the components seen in Figure 5.3 are not unique to ancillary services but may be applied differently than they are elsewhere. Those that have already been described elsewhere will not be repeated here.

Payment Terms

Payment for ancillary services was previously discussed in Chapter 4, and that material will not be repeated here except a reminder that payers routinely negotiate favorable pricing with ancillary services providers. This is especially the case with high volume services like routine laboratory or radiology. Payers may also obtain favorable pricing for certain high-volume routine therapeutic services as well. Ancillary services are also commonly included in hospital contracts, but the cost is typically quite a bit higher than what payers can obtain from independent services providers.

Coverage Limits

As was also mentioned in Chapter 4, payers' often limit coverage of ancillary services in different ways, and payers of any type, not just HMOs, may limit coverage of certain specific ancillary services to only those from specific providers. For example, a Preferred Provider Plan (PPO) may limit coverage of skilled nursing days to designated facilities. The benefits plan may also have hard limits such as the number of visits per year. Coverage of therapeutic services requiring multiple treatments are typically limited to a set number of visits, and concurrent review is used if the therapist believes additional treatments are required.

Apply Standards of Care

As is the case for UM in general, medical necessity criteria typically form the basis for coverage determinations, unless benefits are simply limited by the schedule of benefits or not covered at all. Medical necessity for ancillary services is addressed in the same way as for other clinical services coverage determinations. Standards of care are used for precertification, and evidence-based clinical guidelines may be applied to individual cases. For example, a costly type of imaging procedure may only be covered when standard types of imaging or

other testing do not provide information necessary for an advanced type of treatment.

Monitor Physician Behavior

Most payers use their information systems to look for certain patterns of physician behavior that may indicate a potential utilization problem. But a computer cannot know what to look for on its own—it must be programmed. Because physicians do so many different things, payers often first look for substantial changes in their medical costs showing spikes in utilization, which then give the programmers a focus to program the system. This is most useful when self-referral is involved, which is discussed below.

Physician Feedback

Excessive ordering of ancillary services by some physicians can often be reduced through practice profiling and feedback, as well as direct discussions between the medical director and these physicians. Feedback is most useful when combined with financial incentives such as pay-for-performance (P4P) or capitation described in Chapter 4.

Focused Precertification

Precertification or prior authorization is often focused on costly diagnostic services such as PET scans, MRIs, or some types of genetic testing. High overall costs are not always because of high prices, and may be due to higher than average utilization, or a combination of both pricing and utilization. For example, one of the primary drivers of high imaging utilization is the number of available scanners—that is, the more scanners there are in a community, the more often scans are ordered. It has also been associated with physician self-referral, which is discussed below. Some payers contract with independent companies that specialize in performing focused precertification; for example, a company with radiologists on staff to perform focused precertification of MRIs.

Precertification may be used with therapeutic services, but usually simple notification is enough for certain types of common conditions—for example, extended physical therapy following rotator cuff shoulder surgery.

The Impact of Hospital Consolidation and Physician Employment on Utilization of Ancillary Services

Hospital consolidation and physician employment, described in Chapters 1 and 3, is associated with higher trends in both pricing and utilization. In these situations, hospital-employed physicians may be directed to refer patients to higher-priced hospital-owned facilities and diagnostic centers rather than lower-cost free-standing imaging centers. Payers are limited in how they can respond in these situations other than trying to address payment rates during hospital negotiations. Benefits designs that impose more cost-sharing for using costlier services may also help, but some hospitals may waive the difference, a practice that payers oppose.

Ancillary Services and Physician Self-Referral

Physician self-referral, also addressed in Chapter 3, refers to a situation in which a physician that uses a medical facility (other than their office) or orders ancillary services also has a financial interest in that facility or service; for example, an ambulatory surgical center, an MRI scanner, or physical therapy services. There is compelling evidence that physicians who have a financial interest in a facility or an ancillary services provider will use it far more often than will physicians without a financial interest. That does not mean that the services are never appropriate.

Payers cannot, and do not want to, prevent physicians from ordering ancillary services.

Therefore, payers usually look to see if there are large increases in utilization of a type of service that may signal self-referral; for example, an orthopedic group ordering three times as many MRI tests as other groups for the same number of patients. If that is found, the payer may put in place focused or specialized precertification review that was described earlier.

Ancillary Services and State and Federal Laws and Regulations

The impact of state definitions of Essential Health Benefits (EHBs) and habilitative services was previously described in Chapter 2. It is noted here because it can have a disproportionate impact on coverage of ancillary services, and because state-mandated benefits may also prohibit payers from using some of the usual approaches to manage utilization. For example, a type of treatment by certain non-physician providers may not be required to meet the clinical evidence-based standards applied to other medical/surgical interventions, prohibiting payers from classifying those as not medically necessary and denying coverage.

Management of the Pharmaceutical Benefit

Prior to HMOs, coverage of prescription drugs in group or individual plans was uncommon. Under the 1973 HMO Act as well as state HMO laws, HMOs were not required to cover drugs, but most did though a group coverage benefits rider, meaning an add-on type of policy that was treated separately from the rest of the group coverage. Over time, group benefits drug coverage riders were offered by most types of commercial plans. These riders covered prescription drugs, other than injectable drugs such as insulin or intravenous antibiotics that were typically included under the major medical policy.

When Medicare and Medicaid became law in 1965, traditional Medicare provided no benefits coverage for drugs, but it was covered under traditional Medicaid. The Medicare Modernization Act (MMA) of 2003 created a voluntary prescription drug benefit called Medicare Part D that provided seniors with access to drug coverage through private free-standing MA Prescription Drug Plans (PDPs) or through full-service MA plan that included prescription drugs, called Medicare Advantage Prescription Drug (MA-PD) plans that include a Part D drug benefit. In other words, Part D structured the separate voluntary drug benefit like a benefits rider. PDPs and MA-PDs are described more fully in Chapter 7.

The ACA includes coverage of prescription drugs as one of the EHBs, and though it applies only to insured coverage, self-funded plans typically provide it as well. Even before the ACA, prescription drug benefit coverage for groups was commonly offered by private health insurers, HMOs, and self-funded benefits plans.

The widespread coverage of prescription drugs, combined with drug coverage under the MMA, meant consumers did not have to pay the entire cost out-of-pocket, which fueled rising costs. This trend is evident in **FIGURE 5.4**, which shows total expenditures for prescription drugs from 1971 to 2016. It also affected where costs rose the fastest, as seen in **FIGURE 5.5**, which shows the costs and the sources of payment.

Examples of factors typically affecting drug coverage benefits determinations include, but are not limited to the following:

- Similar drugs may be equally effective in treating the same condition and may have different costs.

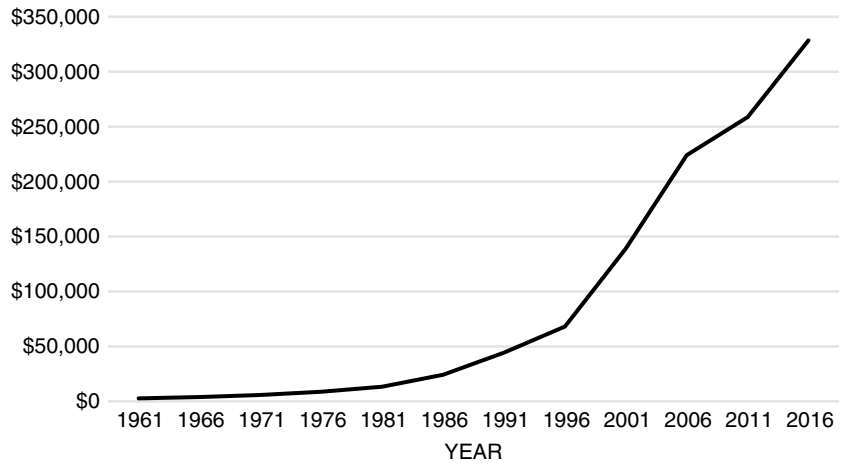

FIGURE 5.4 National Prescription Drug Expenditures (in Millions), 1971–2016

Data compiled by author from National Health Expenditures data released in 2017 by the Centers for Medicare and Medicaid Services.

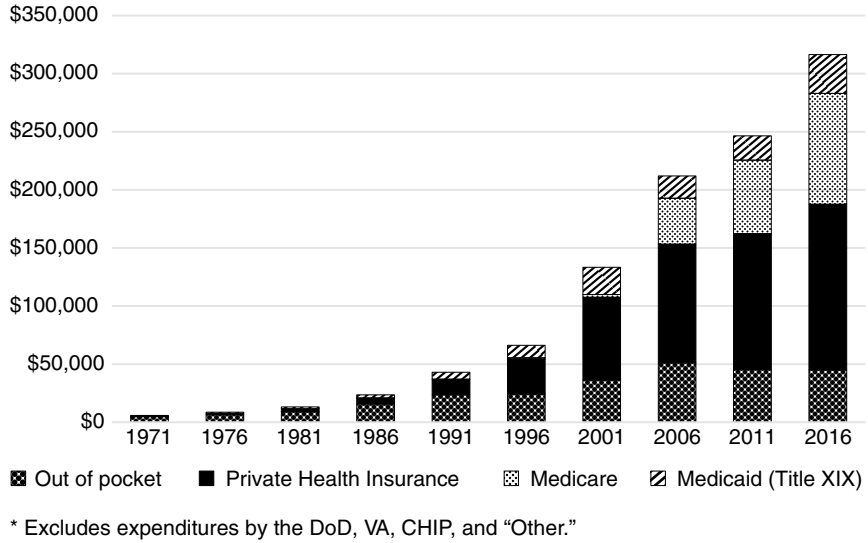

FIGURE 5.5 Sources of Payment for Prescription Drugs (in Millions), 1971–2016*

Data compiled by author from National Health Expenditures data released in 2017 by the Centers for Medicare and Medicaid Services.

- Several different *types* of drugs may sometimes be used for the same condition.
- Some drugs are no longer covered by a patent and may be manufactured as generic medications, whereas others are still under patent protection and are available only as brand-name drugs.

- A generic drug, however, is not always less costly when only one or two manufacturers make it and are able to charge high prices.
- Brand-name drugs are marketed heavily to doctors as well as through direct-to-consumer advertising.
- Some drugs may be equally effective as others for most people, but some people may not respond as well to them.
- Some drugs may be equally effective as others but are not as convenient to take.
- Some drugs may be effective but have fewer or greater side effects than other options.
- Potential serious side effects may be more of a risk for some drugs compared to others.
- Some drugs may be prescribed as "off-label," meaning they are prescribed to treat clinical conditions not included in the list of specific conditions for which the drug is approved by the U.S. Food and Drug Administration (FDA) for use (and therefore usually not covered as a benefit).

Before describing how the drug benefit is managed, it is important to emphasize that prescription drugs may ultimately help lower overall healthcare costs. Prescription drugs are an increasingly important aspect of health care overall, and they are critical to DM and transition management—that is, to managing the care of individuals with multiple chronic conditions and to preventing avoidable readmissions. UM, DM, and CM programs typically rely on claims data to more effectively manage their programs; transition management programs involving payers also use drug claims data, but those operated by hospitals may not have access to it.

Unfortunately, as we saw earlier in the chapter, many people with significant chronic conditions end up in the emergency department or are admitted to the hospital because of problems related to taking—or not taking—their medicines, and the more conditions they have, the more they are at risk. Examples of such problems include, but are not limited to the following:

- People who take many different medicines can become confused and may lose track of what they are supposed to take.
- Some people forget to take all or some medicines.
- Some people do not understand how to take their medicines, despite medical personnel believing they had fully informed them.
- Some people take their medicines at doses or intervals other than what was prescribed.
- Sometimes people stop taking one or more medicines for a variety of reasons, including side effects, real or perceived.
- People with multiple chronic conditions often see multiple physicians, and each may write prescriptions that the other physicians are not aware of, increasing the risk of adverse interactions or double-dosages.
- Some people not on Medicaid cannot afford to pay the high levels of cost-sharing now commonly used for prescribed drugs, and therefore do not benefit from them; there is also evidence that when states impose cost-sharing on Medicaid beneficiaries, even low amounts of cost-sharing for prescription drugs can result in non-compliance.

We saw in Chapter 4 that payment for covered drugs was quite different than other forms of provider payment. Pricing is a core element of managing the cost of the drug benefit, but it is not the only element. Managing prescription drug benefit utilization is the other core element, and while it uses some of the same UM approaches used for medical and surgical care (though in a different way) there are other elements unique to prescription drug coverage.

Pharmacy Benefits Managers

Drug benefits are not only managed differently than other types of healthcare benefits but are often managed by a different company or a specialized subsidiary of a large payer. In either

case, the company or subsidiary managing the drug benefit is called, naturally enough, a pharmacy benefits manager (PBM). For commercial coverage, self-funded benefits plans and private MA-PD plans, the PBM rarely takes any direct financial risk for the cost of the drug benefit because it does not have an insurance license or certificate of authority. In many cases, PBM services are included in a full-services administrative services agreement between a payer and a self-funded plan, but a self-funded plan may instead contract separately with a PBM.

Formulary

A formulary is a list of covered drugs used to treat typical medical needs for almost all conditions, but it usually does not include all available drugs for every medical condition. For example, if several drugs are equally effective for treating the same condition but differ widely in price to the payer or PBM,* the lower cost one will be included in the formulary. In some cases, both drugs may be included but the lower cost one will have lower cost-sharing than the more expensive drug. In this way, the formulary is tightly bound to the benefits design, which will be discussed shortly.

There are two basic types of formularies: open and closed. In an open formulary, all drugs legally prescribed by a physicians or other appropriate provider are covered at least to some degree, but a member will face significant cost sharing for any drugs not on the formulary. In a closed formulary, there is no coverage for any drug not on the formulary, though a physician may request an exception for valid clinical reasons. The use of multiple tiers within a formulary is almost universal in health plans.

Pharmacy and Therapeutics Committee

A Pharmacy and Therapeutics (P&T) committee creates and manages its formulary, using clinical criteria but also taking cost into account when there are two or more drugs that are equally effective. P&T committees rarely if ever are involved with negotiating drug prices, but typically do have the authority and responsibility over approval of a drug's inclusion, and clinical criteria usually take precedence over financial ones. P&T committees are a standard component of a PBM.

Payer or self-funded employer groups may accept a PBM's formulary as is, but many payers—especially large payers and HMOs—have their own P&T committees that adjust the formulary to meet the needs of the plan's network or community, and sometimes to reflect a negotiated agreement between the payer or self-funded group and a drug manufacturer. A payer's P&T committee may also review precertification requests for patient-specific exceptions based on clinical reasons for coverage of drugs not on the formulary; in some cases, exception requests are evaluated automatically based on the physician attesting to the patient's meeting defined criteria. Formularies also typically include the criteria used to determine when an expensive specialty pharmacy drug will be covered, because some drugs may be on the formulary, but only covered if specific criteria are met.

Benefits Design

One aspect of prescription drug coverage changed under the ACA. Specifically, prescription drugs are included as an essential benefit for QHPs, so it is no longer covered under a separate rider. However, the benefits design for drug coverage is not required to mimic the medical/

* Recall from Chapter 4 that for drugs other than specialty pharmacy, the price to the payer or PBM is rarely the same as the retail or "list" price.

surgical benefits design and remains like what was in place before the ACA, as though it was still covered under a separate rider.

Like benefits design overall, the drug benefit design supports the means used by a PBM and a payer to manage costs and access. Examples of four common overlapping benefits designs that apply to most drug coverage are:

- Limitations on Coverage by Pharmacy
- Limitations on Coverage by Drug
- Tiering of Cost-Sharing
- Limitations Based on Medical Necessity

Limitations on Coverage by Pharmacy

As we saw with medical/surgical care, coverage may be limited to drugs dispensed from designated pharmacies. This usually means national or regional chains, but because many states have any-willing-pharmacy laws that require payers to contract with any pharmacy that will agree to the payer's terms and conditions, coverage may also be available from a non-chain pharmacy that can meet the PBM's terms and conditions. Pharmacies may also have coverage limits based on length of time, which is addressed below.

Limitations on Coverage by Drug

Drug coverage benefits may be limited to a certain amount of a drug. For example, drugs for erectile dysfunction in men are often limited to 7–10 tablets per month. Other drugs used strictly for cosmetic purposes, such as drugs for baldness in men, may not be covered at all. Limits also apply to how much a member may obtain for a defined period. For example, it is common for coverage for drugs dispensed by a retail pharmacy to be limited to a 30-day supply. Different limits are applied for mail order dispensing, which is described in the section on Mail Order.

Tiering of Cost-Sharing

Tiering stratifies drugs according to the amount of out-of-pocket member cost-sharing. For example, generic drugs may be classified as Tier 1, in which case the member has a $20.00 copayment.* Certain brand-name drugs that are effective and for which the payer has favorable payment terms may be classified as Tier 2, in which case the member has a $40.00 copayment. Expensive brand-name drugs for which there is a good Tier 1 or 2 alternative may be classified as Tier 3, in which case the member has a $250.00 copayment, or the cost-sharing takes the form of coinsurance, meaning a percent of the cost of the drug instead of a fixed dollar amount. Many payers even designate a fourth tier for drugs for which cost sharing through coinsurance is high; for example, 50% of the cost of the drug.

Because of their high costs, specialty pharmacy medicines are often categorized separately and subject to their own benefits design, usually including coinsurance that varies between 20% and 50% of the cost of the drug.

Limitations Based on Medical Necessity

Like coverage of medical/surgical benefits, drug coverage benefits include definitions of medical necessity. Physicians are able to prescribe any drug for any condition, regardless of how it is designated by the FDA, but drugs may not be covered if they are used off-label, meaning outside of the FDA indications for use.

Coverage of off-label uses is not always sharply defined for many drugs, but it is for others. For example, a new prescription for human growth hormone (HGH or GH) for a 49-year old male is unlikely to be covered except in the rare instance of GH deficiency acquired as an adult. There is no coverage of drugs not approved by the FDA, or that are considered investigational or experimental, unless part of an approved medical research study.

* All cost-sharing dollar amounts are hypothetical and used only for illustration. Actual amounts vary.

Mail Order

Nearly all PBMs provide a mail order service through a subsidiary or contracted licensed pharmacy. Members may be required to use this service for coverage of any long-term or maintenance medications. Mail order services typically dispense a 90-day supply of a drug, but mail order is not used for acute prescriptions that are for 30 days or less, with some exceptions. Mail order lowers the fill fee (i.e., the payment to a pharmacy to fill the prescription) and allows for greater discounts by purchasing drugs in bulk from their manufacturers and/or distributors.

There are two potential problems with mail order dispensing, both having to do with dispensing a 90-day supply. The first is that members may lose or change coverage before 90 days has gone by, meaning the plan paid for drugs for which the former member is no longer covered. The second is that a dosage or the type of drug dispensed may change before the 90-day supply is used up, which is wasteful. Despite these potential problems, using a mail order pharmacy is less costly than retail.

Drug Utilization Review and Step Therapy

Drug utilization review (DUR) consists of activities and strategies for managing the volume and pattern of prescriptions. The most common DUR strategy is to create prescribing profiles and then provide this profile information to physicians so that they can compare their own prescribing patterns with those of their peers.

Another common strategy is to require prior authorization or precertification for new prescriptions of costly drugs, or non-formulary drug exception requests, in combination with step therapy. Step therapy is a form of DUR in which precertification is used for costly drugs for which reasonable alternatives exist, especially specialty pharmacy (discussed next). It is called step therapy because patients must demonstrate that they have side effects from, or an inadequate response to, treatment with less costly alternative drugs. In those cases, coverage for the costlier treatment is authorized. In some cases, such as when an individual changes coverage, the new PBM will require precertification information showing that coverage was previously pre-certified and that the member has been taking the medication for some time.

Specialty Pharmacy

The definition of specialty pharmacy—or more accurately specialty pharmaceuticals—was once limited to biopharmaceuticals, meaning manufactured types of proteins requiring injection either by a provider or by the patient, as well as some agents that are taken by mouth. In the past decade or so, the definition has broadened and now refers to drugs that are very high-cost, complex, require special handling and more provider attention than do regular drugs. Examples include:

- Biopharmaceuticals*
- Costly medicines used to treat rare conditions
- Costly drugs that require special handling or monitoring
- Costly drugs that are available only through very limited supply channels
- Any drug that exceeds some cost threshold—for example, $10,000.00–$100,000.00 or more annually

Examples of diseases and conditions for which specialty pharmacy medicines are commonly used include the following:

- Some common types of genetic diseases, such as the various forms of hemophilia (bleeding disease)
- Some hormone deficiencies, such as HGH deficiency for short stature syndrome in children

* Specialty pharmacy does not include insulin, even though it is technically a biopharmaceutical.

- Certain uncommon genetic illnesses, such as Gaucher's disease, in which the body cannot make a critically important protein
- Certain types of cancers or forms of cancers, such as some lymphomas or certain forms of breast cancer
- Many types of inflammatory diseases, such as eczema, rheumatoid arthritis, or Crohn's disease
- Some other serious medical conditions, such as multiple sclerosis
- Some specific types of chronic infection, such as hepatitis C or human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS)

In recent years, some generic drugs have also come to be included in the category of specialty pharmacy solely based on pricing. This happens most often when a generic drug that is approved for use by the FDA has only one manufacturer, is the only effective treatment for a condition, and in many cases meets the criteria as an "orphan drug" that does not sell in high volume.

Specialty drug treatment ranges from very expensive to jaw-droppingly expensive; in some cases, drug costs can exceed $200,000–$750,000 annually per treated patient. For this reason, even though only 3%–5% of individuals are treated with specialty drugs, they now account for over 40% of total prescription drug spending. About one-third of specialty drug coverage is through the medical/surgical benefit, with the rest provided through the drug benefit in which cost-sharing is higher.

Many specialty pharmacy medicines are riskier for a patient compared to less costly alternatives—a risk that can be worth taking if a patient is not responding well to less costly drugs but not for the sake of convenience or only a minor improvement. Management of the specialty pharmacy benefit is very specialized and is usually managed by a division of a PBM or by a PBM that focuses only on specialty pharmacy. How they manage utilization is generally through DUR and step therapy, often in concert with DM or CM.

Compounding Pharmacies

Compounded pharmacies are another growing cost category for health plans. In compounding, existing medications are mixed together by a pharmacist before being given or administered to a patient. Examples include:

- A drug such as a steroid that is injected into a saline solution bag, so the patient can self-administer an intravenous treatment
- Using portions of an injectable drug and dividing it into small amounts, which are then mixed into a solution to be injected directly into an organ such as the eye
- Several drugs mixed together to create a lotion, salve, or ointment that a patient then applies to a body part, often for pain control

Pricing for compounded pharmacy is not standardized, includes a combination of drug and labor costs, and tends to be very high. There is also a higher potential risk involved when injectable drugs are compounded. For these reasons, plans often use precertification and other DUR methods for these treatments, and they may restrict coverage to medications prepared by specific pharmacies. Reference pricing (described in Chapter 4) may also be used to help manage costs.

Quality Management

All HMOs and POS plans based on HMOs are required to have QM programs under state laws and regulations, and some states require PPOs to have one as well. State requirements around QM apply only to insured plans, however. Private MA and managed Medicaid plans must also have a QM program.

Some large employers require plans to have a QM program, but not all do. Because self-funded benefits plans are not subject to state regulation, a self-funded benefits plan of any type is not required by law to have a QM

program. Self-funded employer groups that contract with HMO, POS, or PPO plans that also have insured products may be included in the plan's QM program because it is already operational. But self-funded groups that contract with rental networks or use different companies for different administrative activities typically do not include QM requirements in their contracts, or only as a minor function.

Payers' QM programs are primarily population based, meaning they look at quality elements applicable to a large portion of the plan's members. They also mostly use the types of data and information readily available to a payer, such as claims data. The QM programs typically look at specific conditions or medical care, such as prevention or treatment of chronic conditions such as diabetes. Payer QM programs are not only population based, however, and have aspects specific to individual members or physicians, too. One example is peer review, which is described later in the section.

Approaches to QM in Managed Care

QM has been an evolving activity for HMOs since passage of the HMO Act of 1973. The classic and most enduring model for QM is that developed by Avedis Donabedian,* which classifies QM activities into three broad and interrelated categories:

- Structure
- Process
- Outcome

In 1999, the Institute of Medicine (IOM) issued two reports on quality, the second of which outlined six goals for providing high quality health care.† These goals call for health care to be:

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

Many HMOs have worked to incorporate the IOM goals into their QM programs. However, the IOM's six goals are provider-oriented. In other words, the primary focus of the IOM report and its goals is how providers deliver health care—for example, reducing medication errors or providing appropriate care more quickly to a patient having a heart attack. But except for group and staff model HMOs, payers are not providers and have little or no ability to directly measure and manage these six goals on a day-to-day or patient-to-patient basis. For that reason, with the limited exception of peer review in some instances, payers' QM focus is on population health using those metrics the payer can measure, mostly (but not exclusively) from using the data they have in their IT systems.

Concepts of TQM, total QI, or continuous QI that emphasize a cycle of measuring, analysis, planning changes, implementing changes, measuring the results, and then beginning the cycle again, are also incorporated into many payers' QM programs.

Sources of Data and Information

As already noted, payers rely primarily on claims data from their own systems as well as drug claims data from the PBM(s) they work with. But payers' QM programs may use other sources of data at times. Examples of some other sources might include the following:

* Donabedian A. Exploration in quality assessment and monitoring: the definition of quality and approaches to its assessment, Vol. 1. Ann Arbor, MI: Health Administration Press; 1980.

† Institute of Medicine. Crossing the quality chasm. Washington, DC: National Academy Press; 2001:5–6.

- Physician medical chart reviews, but only those of the payer's members
- Data obtained during provider credentialing and recredentialing, or through credentials verification
- Member surveys and questionnaires
- Complaints or grievances submitted by members:*
- Information brought to the plan's attention by a plan UM nurse*
- Information brought to the plan's attention by some other source*

The same data source may be used in different ways for different types of studies, as will be described below.

Classic Quality Management

We will focus on Avedis Donabedian's classic model of using structure, process, and outcome because it provides the best structure for understanding QM in managed care. Following that, we will look at peer review as it applies to payers.

Structure

Structure focuses on the context in which care and services are provided, not how care is provided (process) or the result of that care (outcome). Examples of structure measures in a typical QM program include:

- Credentialing criteria
- Network adequacy (see Chapter 3)
- Physical location and accessibility of a physician's office
- Cultural issues such as languages spoken by a physician
- Physical access for disabled individuals

Chart reviews—which are confined to medical records of plan members—may also be part of evaluating structure but are very labor intensive and limited to a small sample of records. Structural medical chart reviews are typically confined to looking at things such as whether the chart lists all the patient's diagnoses, current medications, drug allergies, and so forth. These reviews do not attempt to evaluate how a doctor practices medicine, though chart reviews may also be used for process studies as well.

Structure usually is relatively easy to document, but structural measures are intended only to document that defined baseline standards are being met. Still, structure is a vital part of any QM program, and it is a regulatory requirement established by states for HMOs, though not always for PPOs other than those being offered in a state's health insurance exchange. CMS requires QM to include structure studies for all types of MA plans, and for private managed Medicaid plans.

Process

Process focuses on the way in which certain medical services are provided—in other words, what is being done and how it is being done. Like all measures used in population-based QM, process standards and metrics must be defined beforehand. QM programs select conditions or services to examine based on several criteria. One is whether the conditions or services are common. In this way, they can achieve statistical integrity, meaning the findings are more likely to be valid than if only a few events are observed. Other criteria include conditions or services that are likely to have variations in practice, and the existence of evidence-based medical practice guidelines. Such an approach allows the QM program to affect a reasonably large proportion of the plan's membership and move providers closer to evidence-based practice.

QM process studies also usually depend on data obtainable through the payer's claims data systems, including claims data from PBMs.

* Not always used if it does not indicate a pattern or if the appropriate plan personnel determine that it is not credible.

These claims data are similar to many of those collected for the Healthcare Effectiveness Data Information Set (HEDIS). The claims-based process studies then typically focus on common medical conditions; for example, heart disease, asthma, and diabetes. In this approach, claims data are analyzed to determine whether certain services and treatments are being provided—for example, prescribing beta blockers following a heart attack, or patients with diabetes getting regular blood tests for HgA1c, also called A1c, a measure of long-term control of blood glucose.

Process studies may include chart reviews as well, usually focusing on a random sample of PCPs. When they are used, these reviews focus on selected common conditions (e.g., diabetes or heart disease). The typical approach is to review a set number of a PCP's charts for plan members, and to look for documentation of preventive or screening services, or services related to a specific condition such as counseling a patient with congestive heart failure about lowering salt intake, for example, but not about how the doctor performs a physical exam, or how the physician uses her or his stethoscope, or through any direct observation of patient care. The chart review includes structure assessments too, but the difference is that structure metrics document the presence (or absence) of clinical information, but are unrelated to any specific medical condition.

Payers do not typically perform on-site QM process studies in hospitals or ambulatory facilities. In recent years, some plans have developed target metrics for defined conditions, however, and have begun to require facilities to self-report those data. CMS does this as well, and both CMS and some payers may use those metrics in their pay-for-performance programs.

Outcome

Outcome focuses on the results of care that was or was not provided, but it must be examined in context. For example, a good outcome for a patient who experiences a heart attack would be full recovery without complications, whereas a good outcome for a terminally ill patient might include pain control and the patient and family being kept informed. Because so many factors can influence outcome, it is sometimes difficult to identify the relative importance of any one factor or outcome measure.

Examples of outcomes a payer QM program might look for include the following:

- Member satisfaction
- Infection rates
- Improved long-term blood glucose levels in diabetics
- Fewer emergency department visits
- Fewer avoidable hospital readmissions
- Return to the intensive care unit
- Illness or injury acquired in the hospital or due to provider interventions

It is surprisingly difficult for a payer to use death as an outcome measure. The reason is that death does not generate a billing code, so will not be present in the payer's database. Often the payer does not even know that a member died because they are simply disenrolled from the plan.

Outcome studies are frequently associated with system-wide initiatives. For example, a plan may undertake a focused effort to increase medication compliance by members with congestive heart failure, and then analyze claims data to see if that program results in higher medication compliance and in fewer emergency room visits by those members.

Focused Reviews of Specific Issues

QM programs have mechanisms for performing focused reviews of specific issues such as unreasonable difficulty in obtaining an appointment or unprofessional behavior on the part of a provider's support staff. This type of review is separate from peer review of

physicians, which is addressed in the next section. Complaints and grievances about issues related to the payer's operations area handled through the Member Services department, not QM, and is described in Chapter 6.

There are multiple possible sources of information that may lead a payer to initiate a focused review such as member complaints or grievances related to a provider, whistle-blower calls or emails, and so forth. Because there is always a certain amount of complaints, individuals in the payer's member services or QM department must determine if there are valid issues or there appears to be a pattern. When that is the case, the payer contacts the provider to obtain more information and the payer determines whether to investigate further or resolve it then. There are too many ways a review may be conducted to go into further specifics and possible results.

Peer Review

Most HMOs and POS plans, and many PPOs, have established policies and procedures to evaluate potential service or quality issues related to specific providers. Those policies and procedures may apply to issues involving care provided to plan members by a network provider, and apply as well to the credentialing and recredentialing process, as discussed in Chapter 3 and which is a type of structure study in QM. For that reason, peer review may be used by two different but related committees: one specific to QM and the other specific to the credentialing committee. Both of these efforts are still within the boundaries of QM, however.

Peer review policies and procedures consist of internal information gathering about a specific provider that is relevant to the identified potential issue, review by a plan medical director, and peer review by a physician committee; all are considered part of the peer review process. The entire peer review process, including information gathering, internal evaluations, and deliberations by the peer review committee, is confidential and considered protected information, meaning its confidentiality is protected by federal and state laws and the information is not typically shared outside of the peer review process, though actions taken as a result of peer review may be reportable.

Peer review is used in the credentialing process when a provider's credentials are found to be deficient—for example, when a physician is not board certified and the plan's credentialing policies requires it.* It may also apply when information gathered during credentialing or recredentialing indicates a problem that might not cause the provider to be automatically excluded from the network—for example, several large malpractice awards or settlements in a short period of time.†

In addition to information obtained during credentialing or recredentialing, quality of care concerns about a specific provider or facility may be identified through member complaints or grievances, by a UM nurse during the course of regular inpatient concurrent review, by the actions of another organization (for example, a hospital restricting a physician's privileges), or by actions or sanctions by a state or federal agency.

Potential problems, including complaints or grievances against a contracted provider by a member, are typically reviewed first by a plan medical director after plan personnel have collected any additional relevant information. In some cases, the medical director may determine that no further investigation is necessary. If the medical director concludes that the complaint may have substance, it is typically then referred to the peer review committee.

* Exceptions may apply such physicians newly out of their post-graduate training programs who are not yet eligible to take their specialty boards, in which case they may be provisionally credentialed until they are eligible.

† Once again, exceptions may apply because certain specialties such as high-risk obstetrics and neurosurgery attract a relatively high number of malpractice suits, not all of which have merit.

The peer review committee is made up of plan physicians and supported by non-physician personnel. Physician members of the peer review committee are usually physicians who are in the network and not employees of the health plan. Physicians who are plan employees may be members of the peer review committee but may or may not be able to vote. Some physician members attend all peer review committee meetings, and the committee usually will bring in other professionals with similar training and education to the provider being reviewed on the committee for that case.

The committee reviews relevant information provided by the plan and may request additional information from the plan, the member, and the physician. The process usually allows a physician to confidentially present their view of the alleged deficiency, or lawsuit(s), or event(s), and provide more information to the committee. After reviewing this information, the peer review committee may either close the case or recommend action and follow-up. The provider that is the subject of peer review is informed of any decision made by the committee, but provided no other information in most cases. Likewise, the peer review committee communicates any decisions to the appropriate plan personnel, but again provides no other information. It is done this way so that the peer review confidentiality protections are not accidently violated. An adverse decision may also be reportable to The National Practitioner Data Bank that was described in Chapter 3 in the section on credentialing.

If the quality of care concern is considered serious or an immediate threat to the health of members receiving care from that provider, or if it appears that the provider has broken the law or seriously violated legal or contractual requirements, the medical director and peer review committee may take immediate action—by suspending the provider's participation in the network, for example. Precipitous action by the medical director or the peer review committee can expose the payer to significant liabilities and is disruptive to patient care, so it is not at all common and not done lightly.

Health Plan Accreditation, Certification, and Recognition Programs

Accreditation is a formal process of an external organization determining how well a payer complies with various requirements for UM, QM, member services, provider networks, access to care, and other non-financial activities. In addition to health plan accreditation, the same organizations have other types of recognition and certification programs for specific types of services and organizations.

Health Plan Accreditation

Health plan accreditation is a form of oversight in which an independent, private, nonprofit organization reviews a payer and determines if it meets certain criteria or industry standards. If it meets these standards, the payer is considered accredited, although accreditation levels vary.

In essence, accreditation is a seal of approval that is relied on by many employers and consumers. States also have required standards that the different types of payers must meet, as does CMS for MA plans. Accreditation is not important for all types of health plans, however. On the one end of the continuum are indemnity or service plan health insurers or rental provider networks with few managed care features, for which accreditation may have little value. On the other end are HMOs, for which accreditation is often very valuable or even required. State requirements follow similar lines.

The difference between accreditation and oversight by a government agency such as a

state insurance department is that the accreditation is completely voluntary, whereas compliance with state and federal requirements is not. However, most states as well as CMS accept plan accreditation as meeting regulatory requirements for the functions that are reviewed for accreditation. Data reporting is also an element of some accreditation programs as well as a requirement by most states and CMS.

Under the ACA, plans participating in the health insurance exchanges must also meet standards for qualified health plans (QHPs). These standards are similar to those for health plans generally, but include some additional measures specific to the ACA. The same organizations that accredit health plans for the marketplace and Medicare have established accreditation programs for QHPs.

Accreditation Organizations

Three organizations are recognized as accreditation organizations for payers, and each has additional programs as well:

- National Committee for Quality Assurance (NCQA)
- URAC (formerly called the Utilization Review Accreditation Commission, but now known only by the acronym)
- Accreditation Association for Ambulatory Health Care (AAAHC)

The accreditation process for all three begins with a desk review in which the accreditation organization reviews documentation and data sent by the plan. If the desk review is found to meet the standards, the next step is an on-site review to verify records, interview personnel, and otherwise assess a plan's compliance with the accreditation standards. All three accrediting organizations offer differing levels of accreditation, depending on how completely the plan meets or does not meet its accreditation standards. The accreditation process of all three are similar but not identical, with considerable overlap. All are very comprehensive.

National Committee for Quality Assurance

NCQA has been accrediting HMOs and other health plans since 1990. It was initially formed years earlier by members of the payer industry, but subsequently reorganized so that its governance was made up primarily of representatives from employers, consumers, providers, and regulators (payers are not excluded, but they hold few board seats).

Overall NCQA accreditation covers 62 topics.* Simplistically viewed, overall accreditation status is based on the HMO's performance, including such areas as:

- QM and improvement
- UM
- Credentialing
- Members' rights and responsibilities
- Member connections

The highest levels of accreditation by NCQA also include the following data sets that are briefly described later in the section:

- HEDIS measures
- Member satisfaction using the Consumer Assessment of Health Providers and Systems (CAHPS) survey

URAC

URAC was formed in 1990 with the backing of a broad range of consumers, employers, regulators, providers, and industry representatives to provide an efficient and effective method for evaluating UR processes. Originally, URAC

* Source: http://www.ncqa.org/Portals/0/Programs/Accreditation/HPA/2018_HPA_SGs.pdf?ver=2018-02-16-150007-887. Accessed June 30, 2018.

was incorporated under the name Utilization Review Accreditation Commission. However, that name was shortened to just the acronym URAC in 1996, when URAC began accrediting other types of organizations such as health plans and preferred provider organizations as well as activities other than UR.

The scope of URAC's accreditation program covers 24 topics, covering nearly everything that a managed care plan does. Some of which include:*

- Network adequacy
- Member access
- UM
- QM
- Network management
- Provider credentialing
- Care coordination
- Member services
- Complaints and appeals
- Patient information programs
- Wellness and health promotion
- Medication safety and compliance
- Mental health parity
- Information management
- CAHPS for health plans

URAC does not require HEDIS data, but accepts it as part of its accreditation program.

Accreditation Association for Ambulatory Health Care

AAAHC was formed in 1979 to assist ambulatory healthcare organizations in improving the quality of care provided to patients. The primary areas of focus for AAAHC accreditation are ambulatory healthcare organizations, including endoscopy centers, ambulatory surgery centers, office-based surgery centers, student health centers, and large medical and dental group practices. But it has been accrediting health plans since 1983, though not many plans use it.

Their standards are published in a proprietary book not available for general review. In the past, AAAHC's areas of focus included:

- Rights and responsibilities and protection of members
- Governance and administration
- Provider networks credentialing
- CM and care coordination
- Quality improvement and management
- Clinical records and health information
- Environment care and safety
- Health education and wellness promotion

Standardized Health Plan Datasets and Reports

Three standardized datasets and reports may be used in accreditation, though not for all programs or all levels. In some cases, they must be reported under regulatory requirements. HEDIS and CAHPS may be used in any type of plan. A third report called the Health Outcomes Survey† (HOS) or the Medicare Health Outcomes Survey (MHOS) is used primarily for MA plans. All of these standardized surveys and reports are used to report data and information about overall performance, but also focus on specific clinical conditions and outcomes. HEDIS includes a great deal of plan-generated data, while CAHPS and HOS/MHOS are consumer or member surveys.

Healthcare Effectiveness Data Information Set

HEDIS has become an industry standard for reporting data to employers and many government agencies, and the majority of health

* Source: https://www.urac.org/sites/default/files/standards_measures/pdf/Health%20Plan%20Accreditation%20v7.3%20Standards%20at%20a%20Glance.pdf; accessed June 30, 2018.

† Formerly called the Hospital Outcomes Survey.

plans report HEDIS data. By specifying not only what to measure but also how to measure it, HEDIS allows "apples-to-apples" comparisons between health plans. Every year, national news magazines, local newspapers, employers, and others use HEDIS data to generate health plan report cards during open enrollment. All HEDIS data are required to be independently audited and verified.

HEDIS, which was developed and is continually refined by NCQA, currently consists of approximately 90 measures over six domains of care. Many states require all HMOs to report HEDIS data annually, regardless of whether they use NCQA for accreditation. Different versions of HEDIS focus on commercial plans, MA plans, and Medicaid plans, although all three overlap to a considerable degree.

Consumer Assessment of Health Providers and Systems

CAHPS is an initiative of the federal AHRQ that seeks to support the assessment of consumers' experiences with health care. The goals of the CAHPS program are twofold:

- Develop standardized patient questionnaires that can be used to compare results across sponsors and over time
- Generate tools and resources that sponsors can use to produce understandable and usable comparative information for both consumers and healthcare providers

The first CAHPS survey was developed in 1995 and focused exclusively on Medicare HMOs, and later on Medicaid HMOs. Primarily concerned with consumers' experiences, it examined numerous issues related to member satisfaction and access to care. Since then, the health plan version of CAHPS has continued to evolve and become more sophisticated, and is no longer confined to Medicare and Medicaid plans.

CAHPS for health plans asks questions about access to care, communications, and overall satisfaction; consumers' perceptions of how well a health plan carries out its administrative functions; and consumers' health status and chronic medical conditions. Specialized versions of CAHPS for health plans are used for behavioral health and for children with chronic conditions. NCQA requires that health plans seeking accreditation use a modified version of CAHPS.

In addition to CAHPS for health plans, there are many other types of CAHPS surveys, including:

- Clinician and Medical Group
- Cancer Care
- Surgical Care
- Dental Plans
- Care and Health Outcomes
- American Indian Healthcare
- Child Hospital
- Nursing Home and Family Members
- Patient-Centered Medical Home
- Health Literacy

Health Outcomes Survey/ Medicare Health Outcomes Survey

The HOS was developed through collaboration between CMS and NCQA, which now manages it. Its focus is on Medicare beneficiaries' experiences in the hospital. This instrument includes questions to gain information about the following topics:

- A general health survey
- Information to adjust case mix
- Questions specific to four HEDIS effectiveness of care measures
- Demographic information
- Additional health questions

Focused Accreditation, Certification, and Recognition Programs

The same external organizations that perform health plan accreditation also have other, more

focused programs that award accreditation, certification, or recognition programs for various types of non-standard health plans, and specific types of managed care and provider services.

One of the most important of these is accreditation or certification of Credentials Verification Organizations that were described in Chapter 3 and that are an essential part of physician credentialing by many health plans. The exact array of other accreditation, certification, and recognition programs for health plan services and provider organizations differs from one organization to another. A small set of examples of these include, but are not limited to, the following:

- DM programs
- CM programs
- UR/UM programs
- Independent Review Organizations
- Medication Therapy Management programs
- Managed Behavioral Health Organizations
- Telehealth programs
- PCMHs
- ACOs
- Wellness and Health Promotion programs
- Health Information websites
- Plan Call Center performance
- Dental Health plans
- Workers Compensation Management organizations

Because many health plans or payer companies have many different products, capabilities, and services, the same payer may have accreditation, certification, and recognition designations from more than one of these organizations.

Conclusion

Total medical costs are the product of price multiplied by volume, which equates to provider payment multiplied by medical utilization. Consequently, to manage costs effectively, efforts to obtain a better price for medical services, although necessary for controlling costs, must be combined with UM carried out through a variety of means. Managing costs is not the same as managing quality, so managed care plans use a variety of methods to address quality—but only within the boundaries of what they are capable of doing, because they are not healthcare providers. Accreditation serves to provide independent external assessments of how well a plan meets industry standards in network management, UM, QM, member services, and other functions.

UM and QM are constantly evolving. What worked well 10–15 years ago may now be less valuable and, in some cases, has even been abandoned, replaced by new approaches and methods. As payers and providers become more sophisticated in dealing with issues of utilization and quality of care, managed care will continue to change to take advantage of these improvements.

CHAPTER 6

Sales, Governance, and Administration

LEARNING OBJECTIVES

- Describe the basic structure of governance and management in payer organizations.
- Identify the basic elements of the internal operations of payer organizations:
  - Information technology
  - Marketing and sales, including insurance exchanges
  - Underwriting and premium rate development
  - Eligibility, enrollment, and billing
  - Claims and benefits administration
  - Member services, including appeal rights
  - Statutory accounting and statutory net worth
  - Financial management
- Be familiar with the common potential problems and challenges faced by payers, including those specific to provider-owned or sponsored payer organizations.

Introduction

Sales, governance, and administration (SG&A) is a financial term commonly applied to the various ongoing managerial and operational functions and processes performed by a payer organization. The meaning of sales includes sales, marketing, and public relations. The meaning of governance includes the board of directors and the organization's officers and managers.* The meaning of administration broadly applies to the payer's processes and operations, including network and medical management. This is also referred to as operations.

* More accurately, governance refers to the board of directors, and management to the organization's officers and managers, and there are distinct differences. But there is no need for that distinction from a purely financial point of view, which is why the acronym isn't "SGM&A."

For insured products, the Affordable Care Act (ACA) restricts the percentage of premiums collected by a plan that can be used for SG&A and profit or surplus (for a nonprofit plan). The medical loss ratio (MLR) limit is 80% or higher for products in the individual and small group markets, and 85% for the large group market. In other words, for the individual and small group markets, at least 80% of the premium must be used to pay benefits for medical services, and 85% must be used for benefits in the large group market. Self-funded plans do not pay premiums and are not subject to this requirement.

MLR limits therefore mean that all activities and functions performed by a payer to sell and manage its insured business and for profit (or surplus contribution for nonprofit plans) must come out of the remaining 20% or 15% respectively. The only activities performed by a payer that do not count against the MLR limitation are for wellness and prevention, and for quality management (QM). If the MLR is lower than the limit, the plan must rebate the money back to the customer. MLR limits are addressed further in a later section of the chapter.

Administrative services are often seen as a middleman* and viewed as adding little value. Indeed, during the mid-1990s, the term middleman was wielded as an insult, with many providers and consumers alike believing that administrative services were largely a waste of money that needlessly interfered with medical care. Some providers at that time attempted to take over administrative functions themselves to cut out the middleman—and nearly all of those attempts ended in financial disaster. Any providers that succeeded found that they had to do all the same administrative functions as any payer did, and their administrative costs were also about the same or higher. The key point is that even if one considers administrative services to be a waste of money, no health plan can operate without them, and for many processes no regulator would allow a health plan to operate at all.

Not all administrative or operational functions are discussed here; rather, only the key functions are included. Examples of important functions not addressed in this chapter include:

- Human resources
- Legal and regulatory support
- Compliance
- Facility management
- Mail room management
- Purchasing
- Internal distribution

The topics that are covered will not strictly follow the lettering sequence of SG&A. Instead it makes more sense to follow a different order, beginning with the "G" as we look at the following major administrative functional areas:

- Governance and management
- Information technology (IT)
- Marketing, sales, and distribution
- Actuarial services
- Underwriting and premium rate development
- Eligibility, enrollment, and billing
- Claims and benefits administration
- Member services and appeals of coverage denials
- Financial management

Once these functions have been described at a high level, the chapter closes with a discussion of the most common operational problems that payers, particularly small or rapidly growing payers, may face. That discussion looks at common problems that can affect any type of payer, followed by a discussion of

* The author recognizes that an element in the word middleman is gender specific, but it is the commonly used term so it is used here as well.

common problems faced by provider-owned or sponsored payer organizations.

A note of caution about some of the content of this chapter: the ACA has had and continues to have considerable impact on many of the topics in this chapter, and its greatest impact is on marketing and sales, actuarial services, and underwriting. These same areas have also been subject to political forces that continues up to (and no doubt past) the time of publication. For that reason, descriptions related to the ACA may have changed after publication, so the reader should always seek up-to-date information on those topics.

Finally, this is the longest chapter in this text. The topics covered are essential to the operations of health insurers and payers, but there is no denying that most of us also find discussion of them to be painfully boring. For that reason, the reader may find it helpful to review the chapter in sections, not all at once. Note too that each topic can only be touched upon, not described with any level of detail or completeness.

Governance and Management

Governance and management are not the same thing, although they are related. Governance encompasses the overall policies, rules, goals or mission, and responsibilities for the direction of the organization and oversight of the chief executive officer (CEO). But governance is not responsible for the day-to-day running of the organization, which is the role of management.

The governance and management of a payer organization are influenced by its type, its structure (or that of its parent company), requirements under state or federal laws, and many other variables. In some cases, laws and regulations may only apply to certain product lines such as health maintenance organizations (HMOs) but not to other product lines such as preferred provider organizations (PPOs) even though both are offered by the same company. These variables can affect the governance, and the functions and responsibilities of key officers and managers as well as some committees, but at a high level, the overall needs for governance and management are similar among payer organizations and plan types.

Please note: Any descriptions or statements regarding governance responsibilities in this section (and chapter) represent an overview of typical industry standard practices and are for the purposes of learning only, and they should not be relied upon from a legal standpoint. Reliance can only be placed on the advice of counsel from a knowledgeable attorney.

Board of Directors

Most, but not all, payers have a board of directors. Numerous factors influence the composition and function of the board, including various state and federal laws and regulations affecting board makeup in relation to ownership status, profit versus nonprofit status, and so forth.

Some health plans do not necessarily have their own boards. For example, rental PPOs that do not need a state license; or PPOs, HMOs, or other types of plans created and operated solely to serve a single company's employees. Nevertheless, even some health plans that are not required to have a board often do have one.

Although most payers have boards of directors, not all those boards are fully independent. This is especially true for local or regional payers that are part of large national companies. For example, HMOs are typically required by law to have a local board of directors, but it is not uncommon for a company to use the same corporate officers as the board for all of its subsidiary HMOs. Although this type of board meets the required legal function and obligation, control of the actual governance of the HMO is exerted by the parent

company rather than through a direct relationship between the HMO executives and its local board. These types of boards are not the focus of this section, however.

Board Composition

The composition of the board of directors varies depending on whether the plan is a for-profit entity, in which case the owners' or shareholders' representatives may hold all the seats, or a nonprofit organization, in which case community representation will be broader and the board cannot be dominated by any special interest. Some nonprofit health plans are organized as cooperatives (i.e., a legal entity in which the members, or enrollees, are as a group in control of the entity); in this arrangement, the board members are all members of the plan. The same is true for the few remaining consumer-owned and -operated plans created under the ACA, which are also subject to some other unique requirements. Mutual insurers are similar in theory because they are owned by their policy holders, but their boards more closely resemble the boards of for-profit companies.

Board members generally should be truly independent and have no potential conflicts of interest, or when a potential conflict of interest arises, recuse themselves (meaning abstaining from any discussion or vote). Depending on the situation, local events, company bylaws, and laws and regulations (for example, the tax code for nonprofit health plans) may dictate whether the board members come from outside the health plan and whether health plan executives hold any board seats.

Provider-sponsored nonprofit plans may restrict seats held by providers to no more than 20% of the board's membership for example. A provider-sponsored for-profit plan board of directors will usually be composed of participating providers, but they must take special precautions to avoid antitrust problems. For example, independent providers on the board of a provider-owned plan cannot set or influence how or how much providers are paid unless the providers also share a meaningful degree of financial risk and expenses.

Board Responsibilities

The function of a payer board of directors is governance—that is, overseeing the payer's activities. Final approval of corporate bylaws rests with the board. These bylaws determine the basic structure of authority and responsibility, both that of the plan officers and of the board itself.

As part of their legal responsibilities, members of the board typically review certain reports and sign particular documents. For example, a board officer may be required to sign the quarterly financial report submitted to a state regulatory agency, and the board chairperson may be required to sign any acquisition documents. Related to this are requirements for document retention and access.

Because significant liability issues surround the board of directors, each board member must undertake his or her duties with care and diligence. Plans also usually buy a special type of insurance to financially protect board directors and officers from acts of commission (for something they allegedly did) and omission (for something they allegedly did not do).

In freestanding plans, the board also has responsibility for hiring the CEO of the plan, monitoring the CEO's performance, and determining the CEO's compensation. Many boards may oversee the compensation for all senior executives in the plan.

Typical Board Committees

Most companies have certain board committees that focus on nonmedical issues relevant to running a business. Most states also require HMO boards, and sometimes boards of PPOs, to assume final responsibility for the plan's QM program, even though the board does not actively participate in running it.

Examples of typical board committees include the following:

- *Executive Committee*: Provided with board-level decision making authority for issues that must be addressed before the full board can meet.
- *Finance and/or Audit Committee*: Responsible for direct oversight of issues relating to financial statements and relationships with the outside auditing firm. Reviews financial statistics, approves budgets, sets and approves spending authority, reviews the annual audit, and reviews and approves outside funding sources.
- *Compensation Committee*: Responsible for determining the appropriate compensation and incentives to key executives. The board must also approve and issue stock options to plan officers, board members, and large institutional investors.
- *Quality Management Committee*: Responsible for oversight of the QM program of the plan through regular reports on findings and activities. This board committee, however, does not participate in the plan's internal credentialing, QM, or peer review committees.
- *Corporate Compliance Committee*: Responsible for oversight of the corporate compliance requirements under the Health Insurance Portability and Accountability Act (HIPAA), the ACA, the Sarbanes-Oxley Act, and Medicare and/or Medicaid requirements for payers with those plans.

Management

Management refers to individuals with the authority and responsibility to operate the plan. The roles and titles of the key managers in any organization will vary depending on the type of organization, its legal status, its line of business, its complexity, and whether it is a freestanding entity or a satellite of another operation, among other factors. There is little specific consistency from health plan to health plan, but there is relative consistency in the overall duties described here.

Executive Director/Chief Executive Officer

Most plans have at least one key manager. Sometimes called an executive director, a CEO, a general manager, or a plan manager, this individual is usually responsible for the overall operations of the plan. This is not always the case, however. Many large national or regional payer companies use vertical reporting, in which managers of the various functions such as marketing or network management report to regional managers, not to a plan's executive director.

In freestanding and in traditional nonprofit payer companies, the CEO is responsible for all areas. The other officers and key managers report to the CEO, who in turn reports to the board of directors (or to a regional manager in the case of national companies). The executive director also has responsibility for general administrative operations and public relations.

Medical Director/Chief Medical Officer

Every health insurer and managed care plan will have a medical director, and often more than one. Larger plans typically designate a chief medical officer (CMO*) to whom the other medical directors report. The medical director usually has responsibility for QM, utilization management (UM), and medical policy. In some plans, a medical director is also responsible for provider management and provider recruiting, which may or may not include provider facilities such as hospitals. In addition, medical directors are involved in physician-specific activities such as provider credentialing, peer review, and benefits coverage denials. Under the ACA and in most states, a medical director (one who was not involved

* Not to be confused with a chief marketing officer, who also may be referred to as a CMO.

in the initial denial decision) must review appeals of denials of coverage as well.

Vice President of Network Management

In large health plans and health insurance companies, it is common for provider relations and network management to be the responsibility of an officer other than the medical director. This officer may be a physician, but usually is not. Larger organizations also separate the management and recruiting of professionals from these responsibilities in facilities. Network management is responsible for the credentialing of those providers (see Chapter 3), but a medical director and a credentialing committee, which is a type of peer review committee, are typically responsible for any final deliberations or reviews of provider credentials for professionals. Negotiating and management agreements with rental networks (Chapter 3) also falls to this person.

Finance Director/Chief Financial Officer

In freestanding plans or large operations it is common to have a finance director or chief financial officer (CFO). That individual is generally responsible for all financial and accounting operations, including fiscal reporting, budget preparation, and internal audit.

Operations Director/Chief Operating Officer

Large and sometimes moderate-sized payers often have an operations director or chief operating officer (COO). In very large companies, this position may carry the title of president. The person in this position usually oversees overall operations of the organization, but usually not finance, board and investor relations, and external relations. Strategy is usually the responsibility of the CEO, but a COO/president may assume this role as well.

Marketing Director/Chief Marketing Officer

The responsibility for sales and marketing plan belongs to the marketing director or chief marketing officer (CMO*). These duties generally include oversight of marketing representatives, advertising, client relations, enrollment forecasting, and public relations. In most payers, responsibility for marketing is typically separated from sales.

Director of Information Technology Services/Chief Information Officer

Information technology services (IT, or less commonly IS) are so complex that all health plans have an officer dedicated to overseeing this function. Typical responsibilities of the director of information services or chief information officer (CIO) include oversight of the data center (the physical computing equipment itself), all software and system applications, personal computer networks, telecommunications, Internet portals, and outsourced services. In some cases, plans outsource this function to an independent company.

Chief Underwriting Officer

The chief underwriter is responsible for oversight of actuarial services, which may be provided by in-house actuaries or by external actuarial firms, and for underwriting and generating premium rates. In some payers, actuarial services are part of finance, not underwriting.

Corporate Compliance Officer

Health plans have specific corporate compliance requirements under many different laws

* See previous footnote about CMO also sometimes referring to the Chief Medical Officer.

and regulations. Some of these requirements include appointment of a specific individual who is responsible for ensuring that the organization is in compliance. One corporate compliance officer may be able to fulfill all these responsibilities, but larger organizations may need separate compliance officers for each; for example, there may be different compliance officers for financial matters and for oversight of privacy and security requirements.

Management Committees

The types of operational or corporate committees may vary from one organization to the next. Some may be standing committees that meet on a regular basis for specific purposes, whereas others are ad hoc committees that are created to meet a specific need and then dissolved. Each functional area of a payer organization is likely to have multiple committees, and cross-functional team committees are commonly encountered as well.

In contrast, some committees specifically related to medical management (described in Chapters 3 and 5) and to appeals of coverage denials are similar from plan to plan. The first four of the following medical management committees are found in most health plans, and the remaining two are found in many plans but are not as common:

- QM committee
- Credentialing committee
- Peer review committee
- Pharmacy and therapeutics committee
- Medical advisory committee
- Utilization review/care management committee

Information Technology

The one operational department or function that affects all other is the payer's IT system that includes:

- The computer mainframe hardware, its environment, and its related devices
- Desktop stations, and company personal computers and devices
- Software and supporting systems used on the devices
- Data storage and retrieval systems
- Data and telecommunications systems, including the main "switch,"* and devices that interface with it both locally and remotely
- Security, privacy, protection from electronic threats, and disaster recovery

In other words, IT provides the hardware and software to support the organization; to collect, store, and transmit data; to carry out operational processes; to analyze data and information; and to communicate internally and externally via voice and electronic data interchange. The IT system is the backbone of the payer's operations. Nearly all the activities performed by a payer depend on computer hardware and software. If this information system is not working efficiently and properly, neither is the payer.

The core of most payers' IT system is a mainframe system (sometimes more than one) used to handle high-volume day-to-day operations such as member enrollment and claims. Mainframe systems are usually licensed from a commercial vendor, as is the software used on it, and they typically contain multiple modules for performing different functions. Payers also often license different software modules to perform specific functions and that are compatible with the mainframe system. Examples of such types of separate program modules could include general ledger programs, medical management, and provider contract and database management. Some large plans program their own mainframe systems, and even licensed modules are often heavily modified to suit plan requirements.

The IT system also includes an internal network that supports electronic communication

* The term "switch" is a charming holdover from when telephone systems were routed through a physical switchboard.

within the organization, Internet and e-commerce capabilities for communication with the outside world, and telecommunications systems. In addition, it generally includes private communications systems for business-to-business electronic interchange, data storage, and analysis systems. IT supports all remaining work-related technology used by the organization, including personal computers and mobile devices, and all software licensed by the company. The IT department is also responsible for data security, and for disaster recovery.

While a payer's ability to conduct business and communicate with members, providers, and employers depends on IT, a surprising amount of paper is still used in the business of health care, although it continues to be replaced by electronic forms of information storage and transmission. The IT function often manages this stream of data as well using imaging, optical character recognition, and off-site physical storage.

Administrative Simplification Under the Health Insurance Portability and Accountability Act

Before going on to describe the major administrative and operational functions of a payer organization, it is worth looking at the impact of HIPAA. Although HIPAA was initially drafted as a means of allowing individuals to keep their health insurance under certain circumstances, its biggest impact has come from its Administrative Simplification requirements. HIPAA requires all "covered entities," including payers, providers, and their business associates,* to comply with periodically updated standards in the following areas, all of which are related to IT and affect many of the other core payer processes as well:

- Code sets
- Electronic transactions
- Electronic funds transfers (EFTs)
- Identifiers
- Privacy
- Security

Standardized Code Sets

Standardized code sets were described in Chapter 4 because they all have a direct impact on provider payment, though they are not exclusively used for that purpose. The reader may want to go back and review that section, including the mandatory standardized codes sets listed in Table 4.1 and non-mandatory standardized code sets listed in Table 4.2.

Transaction Standards

Prior to HIPAA, each payer had its own requirements for common types of electronic transactions such as submitting electronic claims. HIPAA mandated that all covered entities use the same standardized transactions. The HIPAA requirements apply only to a subset of business transactions; for example, they do not apply to medical records or communications between providers.

Technical Standards for Transactions Under HIPAA

HIPAA requires certain specific organizations to maintain and periodically update the transaction standards. Transactions other than pharmacy claims are subject to the X12 (sometimes referred to as X12N) standards developed by the American National Standards

* Business associates are companies working for payers or providers that have access to the medical and/or claims data or any personal information about patients or members. HIPAA's administrative simplification requirements do not apply to employer groups or subscribers either.

Institute (ANSI). For pharmacy claims, the designated standards are those of the National Council for Prescription Drug Programs (NCPDP). The ANSI X12 standard transactions are listed in **TABLE 6.1**.

Transaction Implementation Policy Requirements Under the ACA

Electronic transactions standards are highly technical, and they support a degree of flexibility regarding how certain data fields are defined and used. HIPAA set requirements for the use of electronic transaction standards but did not specify how those standards were to be implemented. Payers did all not use the same approach, which created incompatibilities and reduced the potential for administrative savings.

The ACA amended HIPAA to address this inconsistency and directed the U.S. Department of Health and Human Services (DHHS) to develop implementation standards and prohibit payers from creating their own. At the time of this text's publication, most had been created, and the rest will likely be instituted over the years. Like the code sets and transaction standards, implementation standards are designed to be periodically updated.

Electronic Funds Transfers

HIPAA requires payers to use EFTs if a provider requests it. HIPAA does not require a provider to accept EFTs however. A payer can make the use of EFTs a condition of participation in its network, which Medicare does for its traditional program. The standards for EFTs are set by the banking industry, not HIPAA.

TABLE 6.1 Electronic Transaction Standards Required Under HIPAA

Type of Transaction	ANSI X12 Transaction Standard
Eligibility for health plan benefits	270—Request 271—Response
Health claim status	276—Request 277—Response
Electronic funds transfer and remittance advice	835
Health claims or equivalent encounter information; includes coordination of benefits (COB) information	837p—Professional 837i—Institutional 837d—Dental
Health plan enrollment/disenrollment	834
Health plan premium payments	820
Referral certification/authorization	278—Request and Response
Health claims attachments	275

Data from Federal Register for 45 CFR Part 162.

National Identifiers

HIPAA mandates the use of standardized identifiers. For providers, it is called the National Provider Identifier (NPI). The NPI replaced other provider identifiers used by private payers, Medicare and Medicaid. Some provider identifiers were not affected though, such as the taxpayer identifying number, state-issued medical or provider license numbers, and the Drug Enforcement Administration (DEA) number for providers who prescribe or administer prescription drugs. The existing employer identification number (EIN) that is used for tax purposes is used to meet HIPAA's employer identifier requirement.

The NPI is a 10-digit number that is unique and never ending, meaning that once assigned an NPI, the provider will use that identifier for all transactions. This works reasonably well for hospitals and facilities, though health systems can have different NPI numbers for different units. For physicians however, their assigned NPI may not always be the one used to bill for professional services. For example, a physician may practice on some days for a clinic that bills under its own NPI, and on other days work for a group that bills under the group's NPI. There are many other possible ways that physician services may be billed that affect what NPI is used.

HIPAA also required the use of a health plan identifier (HPID) that is to apply to health plans of all types with one exception: If a health plan is a controlled subsidiary health plan, meaning that it is fully controlled by another health plan, then would not need to have its own HPID. However, in 2014 HHS postponed the implementation of the HPID, and as of the time of publication it had still not gone into effect. It is not known when, if ever, it will be implemented.

Privacy and Security Requirements

The privacy and security requirements under HIPAA are complex. States may establish stricter standards than those in HIPAA, but not less strict. These requirements are described here at a very high level, and further information from DHHS about HIPAA and its requirements for privacy and security can be found by navigating from the HIPAA landing page at: https://www.hhs.gov/hipaa/index.html.*

Protected Health Information

Central to the privacy and security regulations is the concept of protected health information (PHI). PHI is individually identifiable health information that is transmitted or maintained in electronic media or in any other form or medium. In other words, all electronic, paper, and oral information is covered. PHI includes all information that is created or received by a covered entity about an individual and that individual's physical or mental health or condition or the health care he or she receives. PHI is individually identifiable because it includes the individual's name or some other information that can be used to identify the individual, such as an address or Social Security number. The definition of PHI is intended to be quite broad and includes most of the information used in managing health benefits plans, including information that is only indirectly related.

Consumers' Control over Their Health Information (Privacy)

Patients have the right to understand and control how their health information is used. The regulations that apply to HIPAA privacy

* Current at the time of publication.

require covered entities to educate patients about their rights, provide patients with access to their own medical records and means to obtain copies of those records, and similar protections. Consumers do not have the right, however, to alter or delete health information created by a covered entity.

Limits on Medical Record Use and Release

With few exceptions, PHI can be used for healthcare purposes only, including health benefits management. Only the minimum necessary information should be disclosed, although that requirement does not apply to the transfer of medical records used for medical treatment or review. The main exceptions to the requirement that PHI be used only for healthcare purposes are some defined and limited marketing, fund-raising, and outreach activities by provider organizations; an individual may also choose to opt out of any such use.

Examples of routine use of PHI that would apply to all covered entities are the use of this information for payment, treatment, and healthcare operations. For example, a hospital must use PHI to both provide care and bill a payer for that care, and a payer must have enough information to accurately process the claim. PHI is used for nearly all major administrative processes, as well as for provider payment, UM, case management (CM), disease management, QM, and similar activities.

Other Administrative Requirements Related to Privacy

HIPAA's privacy provisions also have other administrative requirements, including establishing policies and procedures to protect privacy, designating a privacy official to be responsible for maintaining privacy, workforce training, and having a way for patients or members to file complaints about potential HIPAA violations.

Security Requirements for Physical and Electronic Data

Even though the HIPAA privacy provisions generally require covered entities to ensure the confidentiality of PHI by appropriately securing it, HIPAA has separate security requirements for electronic PHI, including e-mail. Fax, telephone, and paper records are generally not considered electronic PHI unless they are recorded and stored electronically, although these records are still subject to the privacy requirements. Eighteen different standards cover an even larger number of security rules and specifications related to PHI. These complex standards and rules are well beyond the scope of this text but may be found using the URL previously provided.

Analytics and Informatics

Most payers have a department dedicated to using data and information for analytic purposes. This function, often referred to as informatics, may have very specific areas of focus such as medical costs, sales and marketing data, detection of claims fraud, and the like. It may also be more generalized, such as creating ad hoc operational reports for managers on an as needed basis. Regardless, informatics continues to be increasingly important for payers to succeed in today's market.

Marketing and Sales of Commercial Products and Services

Health plans must market to a wide variety of potential customers, from administrative services for large self-funded employer group plans, to insured products for small groups

and individuals. The approach to marketing and sales differs, at least somewhat, for each different type of customer. Many plans participate in Medicare and Medicaid, which have their own stringent rules as discussed in Chapter 7, so those markets are not discussed in this chapter. Payers also typically market and sell other products and services such as group life, disability, and dental insurance, but those are not addressed in this chapter either.

The ACA has had a major impact on certain aspects of how payers market and sell their products. Many ACA requirements are confined to insured products, but some apply to all types of health benefits plans. The federal Centers for Medicare and Medicaid Services (CMS) maintains a website with links to additional information about marketing and sales under the ACA at: http://www.cms.gov/cciio.*

Summary of Benefits and Coverage

The ACA requires all health plans, including self-funded plans, to provide existing and potential enrollees with access to a standardized summary of benefits and coverage (SBC), also called a summary of coverage (SOC). Similar but separate provisions apply to Medicare Advantage (MA) and private managed Medicaid plans. The ACA further requires the SBC to adhere to a uniform and common format that defines the exact information that must be provided so consumers can compare plan benefits among and between carriers. The SBC does not replace the far more detailed evidence of coverage (EOC), sometimes called a certificate of coverage or certificate of insurance, that all health plans must make available to covered individuals.

SBCs must provide information in easy-to-understand language, including a description of coverage, cost sharing, exceptions, limitations on coverage, network access, and the like. It must explain how to renew coverage, include a glossary of common terms, and explain where to go to find out more. It must provide standardized examples to illustrate coverage for some common conditions; for example, birth and delivery, care for diabetes, and emergency care for a broken bone.

Marketing

Although the two functions are closely related to each other, marketing differs from sales. Marketing generally refers to the various activities that support the sales effort and promote the plan in the marketplace, but it usually does not include actual sales. The marketing function in payer organizations typically includes responsibilities such as:

- Brand management
- External communications and public relations
- Advertising
- Market research
- Lead generation
- Sales campaign support

Sales

Sales refer to the processes of selling the plan's products and services to business and/or individuals. It is the concrete means of adding or retaining employer group customers and their employees, and individual members. The sales process differs to some degree by the type of product and by market segments and distribution channels. Sales personnel employed by the plan usually specialize in one type of market segment or distribution channel.

Market Segments

The ACA defines distinct market segments, though its definition of a small employer group was amended in 2016. The market segments under the ACA are:

- Individual: Health insurance purchased individually, not through a group.

* Current at the time of publication.

- Small employer group: An employer that has 1–50 full-time employees,* but the ACA allows states to elect to extend the definition of a small employer to 100.
- Large employer group: An employer that has 51 or more full-time employees on average.

Though not recognized by the ACA, some payers use four, not three levels, by including a mid-sized group market segment applying to groups with more than 50 employees but fewer than 300 or so employees (this can vary from 200 up to 500) and define the large group market as applying to employer groups larger than that. They distinguish this additional type of market segment because the distribution channels often differ for mid-sized and large groups, as discussed next. More importantly, while large groups usually self-insure, mid-sized groups may purchase insured coverage and the ACA's rules for premium rates do not affect insured products other than individual and small group. Self-funded mid-sized groups are typically included in the large group market.

Distribution and Distribution Channels

The term distribution refers to how payers' products and services are sold, and the term distribution channel refers to the way the payer accesses the different types of market segments. Distribution channels may overlap, and sometimes more than one form of distribution may be used in the same market segment. Sales personnel employed by the payer may work with different market segments and distribution channels, as well as direct selling. **TABLE 6.2** lists the most common types of distribution channels.

Individual and Small Business Health Options Program Health Insurance Exchanges Under the Affordable Care Act

Before discussing the insurance exchanges, or marketplaces as the federal government refers to them, recall from this chapter's Introduction that political forces have had the greatest impact on this part of the ACA, and that descriptions here should be verified or updated from current sources as necessary.

The ACA created two similar but distinct distribution channels: health insurance exchanges for use by individuals and the Small Business Health Options Program (SHOP) health insurance exchanges for use by small employer groups. Both are at the state level, and both provide access to purchase coverage during an annual Fall open enrollment period.

As will soon be apparent, exchanges are more than distribution channels, but they are included in this section because their primary function is as a means for purchasing coverage. No individual or small business is required to use an exchange except when receiving a tax credit or subsidy (both are explained in this section), and no payer is required to offer coverage through an exchange.

Under the ACA, each state was to create its own health insurance exchanges, but many states did not. Some states did operate their exchanges but used the federal platform, while the federal government completely runs it in other states. As for SHOP exchanges, at the time of publication, only 33 states ever had them, and the role of the SHOP exchange was substantially reduced by CMS beginning 2018. Small group employers not already using the federal SHOP exchange may only enroll in SHOP insurance—and receive tax credits as noted a bit later—through an insurance

* The ACA also defines a full-time as an employee working at least 30 hours per week or 130 hours per month.

TABLE 6.2 Distribution Channels by Market Segment

Distribution Channel	Individual Market	Small Employer Group Market	Large Employer Group Market
Individual health insurance exchange	Yes	No	No
Small business health options program (SHOP) exchange, if present*	No	Yes	No
Private health insurance exchange	No	Yes	Sometimes for employee coverage options among pre-selected plans
Direct through web	Yes	Yes	No
Direct mail	Yes	Yes	No
Tele-sales	Yes	Yes	No
Retail stores	Yes, but uncommon	Yes, but uncommon	No
Brokers and agents	Yes	Yes	Yes, but less common than in small group market
Benefits consultants	No	Rarely	Yes
Payer-employed sales personnel	Yes, but uncommon	Yes, sometimes with a broker	Yes, but usually with a consultant

*Not all states have a SHOP exchange, and the federal SHOP exchange is now closed to new business and has limited remaining functions.

company or through a SHOP-registered agent or broker, though employers already using the federal SHOP exchange can continue to do so.

The ACA provides for two types of sliding-scale or graduated financial support for qualified individuals and families with incomes between 100% and 400% of the federal poverty level, or between 138% and 400% in states that expanded Medicaid coverage up to 138%. Other requirements besides low income must also be met; for example, not having access to employer-based coverage or to government coverage such as Medicare, Medicaid, or TRICARE; making timely premium payments; and not being claimed as a dependent by another person. Individuals and families that qualify for support can only receive it for coverage obtained through the exchange.

One of the types of financial support is a tax credit that subsidizes the premium cost based on the "Silver" plan, referring to the ACA's Silver level of benefits (see Chapter 2). The other type of financial support is through cost-sharing reductions (CSRs) that reduce the amount of out-of-pocket cost-sharing (also described in Chapter 2) that eligible individuals and families would otherwise pay when receiving medical care. To receive this extra savings, which is different from the tax credits described above, individuals or families must be enrolled in a Silver plan.

The cost of CSR support is absorbed by the participating health plan, which is supposed to then be reimbursed by the federal government. Following the failure to "repeal and replace" the ACA (see Chapter 1) in 2017 the administration stopped funding the cost of the CSR program, though plans in the exchange were and are still required to provide it. Plans that remained in exchanges therefore raised premiums even higher to cover the cost of the CSR subsidy, on top of having increased premiums to offset the increase in adverse selection resulting from the elimination of the individual coverage mandate (see Chapter 2).* For eligible individuals and families however, this did not significantly raise their out-of-pocket cost of coverage because the tax-credit premium subsidies remain intact. Those who purchased coverage through an exchange but were not eligible for financial support had to pay the full cost, so many of them opted to obtain coverage outside the exchange or dropped it altogether.

Like individual premium support tax credits, some small group employers may be eligible to claim the Small Business Health Care Tax Credit. To receive it, the employer must have fewer than 25 full time employees, pay them a relatively low wage, pick up at least half of the cost of coverage, and must purchase coverage through a SHOP exchange (if they are already purchasing through a SHOP exchange), or a SHOP-registered agent or broker. No employer is required to provide coverage to employees who are not full time.

An insurer that chooses to participate in an exchange must offer at least one Gold-level and one Silver-level benefits plan for each exchange product it offers. It is not required to offer Platinum or Bronze plans, although many offer bronze levels too. They are not required to offer the same exchange-based product outside of the exchange, but if they do, they must charge the same premium rates for it.

Participating payers may offer different products through the exchange than they do outside of it, and they usually do. Exchange-based products are often HMOs with narrower, meaning smaller, networks than a payer uses for it non-exchange products, though non-HMO products may be offered as well.

The insurance exchanges have many functions and requirements under the ACA, one of the most important being determining initial or annually redetermining eligibility for subsidies or for coverage under Medicaid. Some functions have not been enforced or congress cut funding to carry them out. Some are being carried out, some have now been delegated to payers participating in the exchange, and some have quietly been shelved. **TABLE 6.3** shows a partial list of some of functions found in the ACA applicable to both individual and (while they continue to operate) SHOP exchanges, and to individual coverage exchanges only.

To meet many of the ACA's requirements, an insurance exchange must also have two-way information exchanges not only with CMS, but with the following entities:

- The U.S. Department of Homeland Security, for validation of citizenship
- The U.S. Department of the Treasury, for reporting of coverage and verification of eligibility for premium subsidies

* Recall from Chapter 2 that after Congress eliminated the individual mandate as of 2019, a few states imposed an individual mandate of their own.

TABLE 6.3 Partial List of Additional Exchange Functions Originally in the ACA

Both Individual and SHOP Exchanges	Individual Coverage Exchanges Only
■ Certifying, recertifying, and decertifying qualified health plans (QHPs) offering coverage through the exchange. ■ Assigning ratings to each plan offered through the exchange on the basis of relative quality and price.[2] ■ Providing consumer information through the SBC for each QHP's offerings. ■ Operating an Internet site and toll-free telephone hotline offering comparative information on QHPs and allowing consumers and small businesses to apply for and purchase coverage if eligible. Determining eligibility for the coverage through the exchange. ■ Determining eligibility for premium subsidies or tax credits. ■ Facilitating enrollment in those programs, by directing consumers to a health plan's website for enrollment or by enabling enrollment on the exchange.	■ Determining exemptions from requirements that individuals carry health insurance, and granting approvals of these exemptions to individuals related to hardship or other criteria.[1] ■ Determining eligibility for coverage outside of the normal enrollment period. ■ Creating an electronic calculator to allow consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions. ■ Managing a navigator program to assist consumers in making choices about their healthcare insurance options and accessing their new healthcare coverage.[3]

Data from PART 2 Consumer Choices and Insurance Competition Through Health Benefit Exchanges; SEC. 1311 [42 U.S.C. 13031] of the Patient Protection and Affordable Care Act.

[1] No longer applicable with the elimination of the individual mandate as of 2019.
[2] Pilot program at time of publication. Health plan rating program to be similar to Medicare Stars program (see Chapter 7).
[3] Funding cut, and not performed by all states.

- State Medicaid agencies, for determination of eligibility for Medicaid coverage, including facilitating enrollment
- Health insurers and HMOs participating in the exchanges for a wide variety of transactions

The exchanges had a very rocky start, mostly because the newly programmed IT systems were overwhelmed. Those IT problems were successfully addressed after the first year or so, but exchanges have continued to face challenges, primarily because of the high cost of coverage. Premium increases in exchange-based coverage were expected to be higher than average because of adverse selection, meaning attracting individuals with significantly higher than average risks for medical costs. To address that, the ACA included payer protections through "the three r's" meaning risk adjustment (also called risk payment transfers), reinsurance, and risk-corridors.

Reinsurance was underfunded and quickly ran out of money. Congress cut funding for risk corridors when political control changed in the House, so the federal government could not pay what it already owed, resulting in payer losses. Reinsurance and risk corridors were temporary measures and have expired. Risk transfer payments are a permanent feature of the ACA in which payers enrolling members through an exchange with lower average risk

must transfer (via the federal government) some premium to those payers with higher average risk. The actual fund transfer was temporarily halted in 2018, but has resumed as of the time of publication.

Initially there were multiple payers participating in exchanges, but by 2015 the number of plans offering products through exchanges was small. Beginning in 2017 some plans reentered and there were some new entrants too, and most locales had at least one participating payer. Even with the turmoil, the number of people who obtain coverage through exchanges has remained stable, despite a change that shortened the length of open enrollment. Premium increases have been high, especially in the Silver Plan where well over three quarters of those with coverage receive some level of subsidization.

Private Health Insurance Exchanges

Private health insurance exchanges are not the same as the exchanges under the ACA. Private exchanges are private commercial web-based marketplaces operated by payers or by benefits consulting firms. They focus primarily on small- to mid-sized employer groups, though some large employers are using them too, but they do not offer individual coverage. Many also offer non-health benefits products such as life or disability insurance.

Private health exchanges are both a form of a digital distribution channel and a means of providing more services to employers and their employees. They are self-service sites that replace at least some traditional sales approaches and, therefore, can lower sales costs. Private exchanges can also generate revenue to the company sponsoring the private exchange by using captive, meaning directly employed, agents and brokers that are paid through sales commissions.

Some private exchanges may provide overall benefits administration services to smaller employers for less than it would cost the employers to do it themselves. Payer companies that offer private exchanges often use them to allow the employees from a group of customers to choose from various coverage options offered by the payer rather than imposing a single type of benefit plan—something most large employers have been doing for many years.

Web Sales

All or nearly all payers and health plans have web-based portals. Many portals include direct purchase of coverage for eligible individuals or small businesses, although they require individuals to go through an exchange first to determine eligibility for coverage subsidies through an exchange or for Medicaid coverage. Online brokers may also run web-based sales portals, and plans often provide web-based sales tools to brokers to be used in selling to consumers.

Direct Mail

Direct mail to consumers and/or small businesses was once a common sales tool, but it has been supplemented or replaced by electronic media, at least in the commercial market. But it is still heavily used for MA (Chapter 7), in markets where a single employer has a very large number of employees, and with government employees. In all instances, most direct mail is sent during or just before open enrollment periods. State insurance exchanges also used it during open enrollment, but that fell off when Congress eliminated funding. A mailing may be informational only, directing the individual or business owner to another channel, or it may provide an application form that can be mailed or faxed in.

Tele-Sales

Tele-sales are common in the Medicare market during the Fall open enrollment period when individual beneficiaries can choose to be covered by an MA plan and/or a Part D prescription drug plan, keep traditional Medicare coverage, with or without also buying a

Medicare Supplemental Coverage (Medi-Gap) policy. Tele-sales are occasionally used in the small group market. They were initially used during open enrollment for individual insurance exchanges, but that is now uncommon.

Most tele-sales calls are pre-recorded robocalls made by computers over inexpensive Voice-Over-Internet-Protocol connections, using predictive dialing that calls when most people will be at home, such as dinner time. Anybody who does not hang up is directed to press a key or say a word such as "yes" to talk to a live sales representative. Some tele-sales calls are made by living people located where labor costs are low, using the same technology but working from a script.

Retail Stores

Sometimes health plans set up stores or storefronts that enable walk-in, in-person purchasing of health insurance. Sales associates in the retail store consultatively engage the consumers and guide them through the purchase process. This avenue is not a commonly used distribution channel, but when it is used, other channels (e.g., web, direct mail, tele-sales) and media (print, radio, and television) are leveraged to stimulate traffic to the retail store.

Brokers and Agents

Brokers and agents are major distribution channels in the individual, and the small and mid-sized employer group markets. Most products sold by brokers are insured, but some occasionally sell reinsurance and TPA services to self-funded business too.

Brokers must be licensed by the state in which they work, and they must be appointed or certified by an insurer or HMO before being able to sell any of the plan's products. Some brokers may also sell products offered in an exchange but must be certified to do so. Special certification is required for brokers to sell MA products.

Brokers and agents are paid a commission by the health plan. In the past, this usually means a percentage of the premiums paid by the employer or individual that bought coverage through the broker. That meant that as healthcare cost inflation drove premiums up, the amount paid to brokers rose at the same rate. Plans could not or did not vary premiums depending on whether a broker was involved. In response to the MLR limits created by the ACA, some plans now pay brokers through a flat commission payment, meaning a fixed dollar amount. Percentage of premium commissions is still used, however, and where the individual and small group markets are quite competitive, commissions are higher. Broker commissions for MA products are set by the federal government and discussed in Chapter 7.

Benefits Consultants

Benefits consultants focus on larger, self-funded employers. Consultants are paid by the employer, not the payer, and their payments usually take the form of fixed fees unrelated to the amount of premium, not by commissions. Benefits consultants help employers to negotiate administrative agreements with payers, obtain reinsurance, and often manage nonmedical benefits. In many cases, benefits consulting firms may manage all aspects of all employee benefits programs for a large employer, though usually not payroll.

Sales Personnel Employed by the Payer

Payers employ sales personnel who work in a variety of capacities. They often specialize or focus on specific types of sales, such as direct sales to small- and mid-sized employer groups, sales to individuals, working mostly with brokers, or working with benefits consultants. States require employed sales personnel to be licensed to sell insured products, and special certifications are required to sell Medicare products.

Sales in the large group market usually involve two types of sales. The first sale is to the employer group. But large employers typically

contract with more than one payer to provide their employees with choices in benefits plans and costs, and this means a second sale. The second sale refers to selling to each individual employee—that is, persuading the employee to choose one payer over another. Some large companies restrict how a payer handles this contact with employees during the employer's open enrollment period—for example, by controlling the types of information a payer can make available to employees, or by limiting the locations and allowed time for sales presentations to employees and dependents.

Seasonality

Finally, there is seasonality to marketing and sales. Most sales occur in the Fall for an effective date of January 1, which is the case for all individual business. But most groups also have open enrollment in the Fall, and it is common for well over half of a payer's marketing and sales activity to take place then. The remaining sales often have another, smaller surge in the Spring, with the rest being spread out over the course of the year.

Actuarial Services, Underwriting, and Premium Rate Development

A fundamental requirement for any payer is to know what to charge in premiums for its insured products. Because of the MLR limits, overcharging results in having to pay rebates to individual and small group market customers, and undercharging means having to deal with premium payments that are insufficient to cover costs for a full year—known as a "premium deficiency" in the industry—without ever being able to recover the losses. It is the responsibility of the related but distinct actuarial and underwriting functions to, among other responsibilities, calculate what the premiums need to be each year for each product to cover costs and produce a positive margin or surplus while remaining competitive.

Actuarial Services

The most important things that actuaries in the payer sector do are to estimate current medical claim liabilities and future medical expenses by building on past and current experiences. The estimates of future medical expenses are influenced by the design of the benefits plan, changes in laws such as benefits mandates, provider payment rates and types of payment, assumptions about utilization trends, and so forth. The result is an actuarial model in which these factors are used to estimate the average amount of money required to cover medical costs on a per-member per-month (PMPM) basis. Actuarial models and projections are used as a basis for developing premium rates, but the actual premiums will differ from those base numbers.

Actuaries are often also responsible for performing ongoing estimates of how much money a plan needs to reserve to cover expected costs that are known and unknown (more on this later in the chapter), though this may be performed by financial managers on a day-to-day basis. Small- and mid-sized payers typically engage external actuarial firms rather than hire staff actuaries when actuarial services are needed for operational or financial management purposes. Regardless of the presence of staff actuaries, states require a certified opinion by an independent actuarial firm just as they do the opinion of an external certified accounting firm as part of a health plan's annual audit, and most large accounting attestation firms have both types of professionals.

Underwriting and Premium Rate Development

To calculate the premiums that will be charged, underwriters begin with the amount the

actuaries calculate. This may include a determination of the levels of risk for groups and products. Certain requirements of the ACA have a large impact on risk affecting premium rate development for the individual and group markets, including:

- Guaranteed issue and renewability
- MLR limitations
- Restrictions on age banding
- Whether the payer offers any products on a health insurance exchange

These will be briefly described shortly. Other factors affecting premium rates include cost-sharing and product design, policy or contract size, community rating requirements by the state, and, under the ACA, and mandated benefits.

The ACA has far fewer requirements affecting large groups, so underwriters use experience that is much less affected by the provisions noted above. Self-funded, also called self-insured, groups do not pay premiums, but payers may still calculate imputed rates, meaning what the premium rate would be if the group was insured, that the employer can use for its own purposes. This will also be addressed further in the section.

Guaranteed Issue and Renewability

All insurers and HMOs are required under the ACA to provide guaranteed issue and renewability, meaning that no group or individual may be denied coverage through an available plan. Renewability means that any person or group that is currently covered will be able to renew coverage if premiums have been paid and no fraud has been committed, though coverage terms may vary from year to year. Guaranteed issue means a policy will be issued as long as they apply during the annual open enrollment period (which usually takes place once per year), or within 60 days of a qualifying event (also called a life event or a special event) described later in the chapter, have not failed to pay their premiums, and have not committed fraud.

Guaranteed issue results in a higher level of financial risk to insurers and HMOs because sicker people are more likely to want and need coverage than are healthier people, and payers may not exclude them from coverage unless the payer sells no individual products where a person resides. Because health insurance is expensive, sick people will pay for it if they can, but healthy people may choose to take their chances, especially after the individual mandate was eliminated.

When sick people opt in while healthy people opt out, the risk pool of covered individuals has adverse selection, meaning it is sicker than average, and underwriters must factor that in when calculating premiums. As costs rise because of the higher than average health needs of the pool of people covered, costs rise faster than average as well, which can drive even more healthier people from the risk pool, a process referred to as the "insurance death spiral," meaning eventually costs might become so high that no amount of premiums can cover it and the plan fails.*

Medical Loss Ratio Limitations

The ACA placed limits on the MLR, meaning the percentage of premium dollars spent on clinical services and quality improvement, and must rebate the difference if the percentage of premium spent on clinical services and quality is less than 85% for plans in the large group market and less than 80% for plans in the individual and small group markets. MA and private managed Medicaid plans must comply with the 85% limit.

* A payer can withstand having a product or plan with adverse risk and losses if its overall product portfolio has a net positive margin.

The MLR limit does not apply to self-funded groups because they pay only administrative fees, not premiums. A few other types of coverage such as so-called "mini-med" plans with very limited benefits, student health plans, and overseas coverage have different formulas for calculating the MLR.

In the individual and small group markets, the rebates are paid out evenly to each covered individual or small employer group, in proportion to how much they paid in premiums. In the large group market, rebates are paid on a company-specific basis, meaning they are paid only to companies for which the MLR was less than 85%. Rebates do not necessarily need to be paid directly, they can be used to offset premium costs for the next year.

The MLR limitation operates in one direction only; if a plan experiences a higher than expected MLR, meaning it spends more on benefits than it anticipated, it cannot recover the difference. The MLR requirement also does not allow a payer to use a group's overall medical costs if it is providing coverage for an employer with locations in more than one state; instead, the MLRs are calculated exclusively on a state-by-state basis. In other words, if a single large group employer has an MLR of 75% in one state but an MLR of 92% in an adjoining state, the insurer must rebate 10% of the premiums for the first state and is not allowed to apply that rebate to losses experienced in the second state. The MLR cannot be averaged over time, either; separate calculations are made for each year.

Underwriters must take MLR requirements into account. However, because plans must pay rebates but cannot recover any losses, underwriters are particularly careful to not calculate rates that are too low because low rates will incur unrecoverable losses for an entire year. On the other hand, as medical costs grow, so too do the whole dollars that a percentage of premium represents.

Age Banding or Age Brackets

Age banding means charging different premiums to people based on their age, or to groups based on average age. This is done because on average, older people incur higher costs for health care than do younger people. The ACA allows age banding but limits it to no more than 3:1, meaning that older people can only be charged rates that are no more than three times higher than younger people. Underwriters must project the number of people in each age bracket as part of calculating premiums.

Age banding restrictions lower costs for older people, making coverage more affordable, but raises it for younger people. This can lead younger (and presumably healthier) people to not buy coverage, which results in adverse selection. To counteract this to a small degree, the ACA allows for individuals below the age of 30 to buy a "catastrophic" health plan with very high cost-sharing.

Smoking Surcharge and Premium Credits for Participation in a Qualified Wellness Program

Under the ACA, smokers may be required to pay a 50% surcharge on top of their premium. The ACA also allows employers to offer a premium credit for participation in a qualified wellness program (or a reasonable alternative). There are several conditions a wellness program must meet to qualify, and members must be allowed the option to participate each year.

There are two types of wellness programs that may be used for this credit: Activity-only and outcome-based. Activity-only requires participation in an activity but there is no specific outcome. Outcome-based requires the participant to achieve a specific goal such as losing weight. The maximum premium credit that may be applied for a wellness program other than smoking cessation is 30%, though most employers use more modest amounts. The credit that may apply to smoking cessation is 50%, which offsets the premium penalty imposed on smokers.

Cost-Sharing and Product Design

Benefits design and cost sharing for each product in each market segment or large group is another factor in premium calculations. As the amount of cost-sharing goes up, premium rates go down. This occurs for two reasons. The first and most obvious reason is that any amount paid by individuals in cost sharing is not paid by the plan. The second reason is that as the amount of cost sharing rises, people tend to use fewer medical services or are more willing to choose less costly alternatives, which is called behavioral shift, as discussed in Chapter 5.

Cost-sharing is a major and common element of benefit design, but there are also difference by product type. HMOs usually have lower utilization than PPOs or other products and may have better provider payment terms as well. To the extent an HMO uses provider risk-sharing, that too offsets cost increases to some degree. But HMOs also provide richer benefits and less cost-sharing, which can offset less utilization.

Policy or Contract Size

The next element to be applied is the mix of adults and children, referred to as policy or contract size. In this case, the contract is the insurance policy, not the contract with an employer group. The monthly rate charged to a single individual is always higher than the PMPM actuarial base cost, and monthly family rates are lower than what they would be if each person were charged the same base amount. The reason for this difference is that the average medical costs for children are far lower than they are for adults.

For this same reason, premium rates are often calculated for different mixes of adults and children. For example, underwriters may calculate different rates for single coverage versus family coverage, or different rates for different combinations of subscribers and dependents such as:

- Single coverage only
- Two adults only
- One adult plus one or more children
- Two adults plus one or more children

Community Rating

The ACA requires insurers and HMOs to use community rating in the individual and small group markets, and for any products they sell through the exchange. Payers usually keep the risk pools separate so that community rates for the individual market will differ from those in the small group market. States may combine them if they want to do so. Community rating means that premium rates cannot be different for people or small groups that are sicker or healthier than average. Instead, the overall average forms the basis of the rates. The exceptions to this are age banding, rate increases related to smoking, and wellness-related premium credits that were described earlier.

Regulatory Rate Approval

The ACA requires state review and approval of community rates in the individual and small group markets, and for plans to justify increases. However, the ACA does not give the federal government any direct control in most cases, and states vary in how they conduct their review and approval processes, with some states forcing payers to lower rate increases even when it will result in a substantial loss, while other states rarely intervene. In all cases, the responsibility of a state's insurance department is to protect consumers, and that includes regulations to avoid having a health insurer exit the market resulting in no available coverage for consumers, or incurring such losses as to place it in danger of survival.* A few states do not have what CMS considers

* To illustrate this, when the administration refused to pay participating plans for the cost of the CSRs as described earlier in the chapter, many state insurance departments worked quickly with exchange plans to incorporate that cost into upcoming Silver Plan rates where the CSRs were used.

to be an effective rate review process, in which case the responsibility does fall to CMS.

Experience Rating in the Mid-Sized and Large Group Markets

Experience rating may be used for fully insured employer groups with more than 50 employees, meaning the rates reflect the actual medical cost experience of an employer group. As a practical matter, how much experience affects rates is related to how many employees are in the group, because the smaller the group, the larger the impact of random chance. But in general, if a large group has had high medical expenses in the past, it will be charged a higher premium than a group whose medical costs have been low. MLR limits still apply.

Underwriters calculating experience rates try to differentiate between trends and just plain bad luck. For example, a group may have high expenses in a year because of a single very high cost case, referred to as a shock claim, that is not ongoing. Conversely, another group's high expenses may be due to ongoing factors—for example, a group such as the National Association of Asbestos-Smoking Snack Food Enthusiasts.* The first group's prior year's high expenses were caused by bad luck and do not indicate that its expenses will remain high, whereas the high expenses of the second group are likely to continue, at least for the few remaining years they may live.

Determination of Premium Equivalent or Imputed Premium Rates for Self-Funded Employer Groups

Self-funded employer groups are not insured by a health insurer or HMO, although they typically do purchase reinsurance. Nevertheless, even a self-insured employer needs to have rates calculated so that the employer knows the likely future cost of employee health benefits and can determine how much the employees must contribute through payroll deductions. These are not true premium rates, but rather are typically referred to as a premium equivalent or imputed premiums. The calculations are often done by the underwriters of a payer contracted to administer the benefits plan, or they may be performed by an actuarial firm or the employer's benefits consultants. In either case, the methods used are similar to those described for experience-rated large groups.

Eligibility

Chapter 2 introduced the concept of eligibility for coverage, and how there are different types of eligibility, and it has been included in other sections of the chapter, but it's time to pull it together, at least for coverage in the commercial market. Eligibility for Medicare and Medicaid plans is addressed separately in Chapter 7. There are three broad categories of eligibility for coverage in the commercial market:

- Eligibility for coverage through an employer-sponsored group benefits plan
- Eligibility for individual coverage
- Eligibility for coverage based on qualified events, sometimes called life events or special events

Eligibility for Coverage Through an Employer-Sponsored Group Benefits Plan

Employers are not compelled to offer group health benefits, so employment by itself does not necessarily mean an employee will have health insurance. However, the ACA created penalties for employers with 50 or more employees if they do not offer coverage, though there are many situations in which penalties would not be applied, and penalty costs are

* Thankfully this is not a real group.

generally lower than are coverage costs. The ACA also created tax-credit incentives for qualified small group employers if they offer coverage. In any case, most large employers offer health benefits coverage to their employees, and many smaller employers offer coverage as well. If an employer does offer this benefit, coverage cannot discriminate between people based on such factors as income, position in the company, or health status.

Nothing compels an employee to take up the employer-offered coverage. The individual mandate certainly created an incentive to take it but was eliminated as of 2019 as noted earlier. Some employees who do not take up coverage go without, but some don't need it because they are covered under a working spouse's health plan.

In the large group market, employers typically have an annual open enrollment period if they offer more than one plan, which large employer groups almost always do. The annual open enrollment period is the only time when employees can change plans except in the case of a qualifying event. New employees must enroll within a specific time period after coming on board, typically 30 days, or they lose eligibility until the next open enrollment period. In some cases, a waiting period applies before a new employee is eligible to join the employer's plan, but the ACA limits any waiting period to no more than 90 days. In the small group market, small groups are eligible to purchase coverage through the SHOP exchange (if they are already purchasing through a SHOP exchange); a SHOP-registered agent, or broker; or through guaranteed issue benefits plans during the same open enrollment period in the fall of each year that applies to the individual market.

Eligibility for Individual Coverage

Eligibility for individual coverage applies to coverage for individuals and families that do not have access to coverage from other sources and meet other requirements such as timely payment of premiums and not being claimed as a dependent by somebody else. Eligibility in this case means the ability to purchase coverage through the health insurance exchanges operating in their states, through a qualified broker, or from any qualified carrier offering individual policies.

Eligibility for Coverage Based on Qualifying Events

A person of family may qualify for coverage outside of an open enrollment period based on changes that occur in an individual's life, which are called qualifying events or sometimes life events. Qualifying events are defined in several federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the federal Employee Retirement Income Security Act (ERISA), HIPAA, and the ACA. State laws and regulations can also affect eligibility from a qualifying event and may provide greater protections than federal laws, but not less. When a qualifying event occurs, an individual or that individual's dependents qualify for coverage but must act within a defined time period, usually 60 days from the event. If they fail to do so, then they lose eligibility for coverage outside of the regular open enrollment period.

There is more than one type of eligibility associated with various qualifying events. Examples include:

- Changes to existing employer-based coverage
- Extension of employer-based coverage
- Subsidized coverage through an exchange
- Non-subsidized coverage through an exchange
- Coverage under Medicaid
- Coverage under Medicare
- Other events and options.

One example to illustrate this is COBRA, in which people who lose their employer-based group coverage due to a qualifying event are usually able to extend that coverage for up to 18 months (or 36 months in some cases). The individual must pay the full premium

TABLE 6.4 Examples of Qualifying Events

Type of Event	Examples
Job change	■ Become eligible for coverage through new employer ■ Become eligible for coverage through exchange if new employer does not offer coverage or employment is part-time only
Loss of health coverage	■ Losing existing health coverage, including job based, individual, and student plans ■ Losing eligibility for Medicare, Medicaid, or CHIP ■ Turning 26 and losing coverage through a parent's plan
Changes in household	■ Getting married or divorced ■ Having a baby or adopting a child ■ Death in the family
Changes in residence	■ Moving to a different ZIP code or county ■ A student moving to or from the place they attend school ■ A seasonal worker moving to or from the place they both live and work ■ Moving to or from a shelter or other transitional housing
Other	■ Changes in income that affect the coverage for which one qualifies ■ Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act Corporation shareholder ■ Becoming a U.S. citizen ■ Leaving incarceration (jail or prison) ■ AmeriCorps members starting or ending their service ■ Experiencing a Marketplace enrollment or plan information display error ■ Getting a favorable coverage appeal decision

Data from Healthcare.gov at https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

plus 2%, and any failure to pay results in loss of coverage and loss of eligibility for COBRA continuation. The cost of coverage under a COBRA extension is often less than coverage through an exchange unless the individual or family qualifies for financial support. Once eligibility for coverage under COBRA runs out, coverage may be extended under HIPAA—although there is no longer any need for that option—or coverage may be obtained through an exchange.

Other examples to illustrate this include the birth or adoption of a new child or dependent, in which case the new dependent can be added to existing coverage within the allowable time frame. Marriage or divorce is similar except one adds coverage and the other results in eligibility for coverage extension under COBRA.

TABLE 6.4 provides some examples of most of the common types of qualifying events.

Enrollment and Billing

Enrollment means creating a record in the payer's transactional processing system that an individual is enrolled and eligible for benefits

coverage, now or in the future; and linking that record to a specific type of plan, a specific benefits schedule, and a specific network of contracted providers. It is the basis for many of the other transactions that take place in a payer organization, including claims processing, member services, and medical management.

Billing is how the payer itself is paid. For insured or at-risk commercial businesses, bills are generated for premiums. For self-funded accounts, bills are generated for administrative fees only. Some large employers self-bill and periodically reconcile with the payer. Billing is also a dynamic process, with interactions affecting billing, payment, reconciliations, and enrollment changes occurring daily, not just during open enrollment periods.

Eligibility, enrollment, and billing in the commercial market differs for group coverage and for commercial individual coverage. The ACA also—theoretically at least—enabled a new avenue for enrollment and billing through the health insurance exchanges for individuals and small employer groups, but it has not been implemented.

Enrollment

Enrollment is a dynamic process, with changes being made every day and seasonal surges in enrollment occurring during open enrollment periods in all markets. Benefits plan changes for existing members require changes in the enrollment system on an ongoing basis; for example, changes from qualifying events, new hires, or leaving employment that results either in a COBRA benefits extension or in simply disenrolling that individual or family from coverage.

Sources of Enrollment Data

Enrollment in employer-based group plans begins with the employer. In most cases, the employer is responsible for providing the payer with accurate and timely data on the employees and dependents covered under its plan as well as identifying those individuals who are no longer covered. This includes new employees as well as those employees who gain, extend, or lose coverage through qualifying events. The enrollment information may be transmitted through paper forms, computer tape cassettes, non-volatile digital storage containers, optical media, batched electronic transmissions, or input directly by the employer's personnel department into the payer's system. In some cases, employees apply or make changes through a dedicated web portal.

Enrollment in individual coverage may also occur through direct interaction between an individual or employer and an insurer or HMO, in which case the data and information come through the plan's website or through data entered on a paper form. Agents and brokers may also assist but cannot fill out enrollment forms on somebody's behalf. Individuals must first go through the process to determine if they are eligible for subsidies as described earlier.

Enrollment Errors

Enrollment errors can be caused by both internal and external factors and can affect operations throughout a payer organization. Errors add to administrative costs because resolving them often takes manual work. Errors in enrollment can result in payment of claims for someone who is no longer covered or denial of payment for someone who is covered, incorrect capitation payments, more calls to member services from angry members, provider verification of coverage problems (described shortly) and so forth.

Internal errors in enrollment are often the result of enrollment backlogs that occur during heavy enrollment periods, particularly from the fall through the end of January, when the largest number of open enrollment periods take place. In addition, they can result from paper enrollment forms being incorrectly read by the optical recognition system and not corrected manually.

Errors in enrollment can occur for a variety of external reasons as well. In the group

market, an employer may transmit inaccurate or late data about who has been hired or is no longer employed, which employees changed from one plan option to another, changes based on qualifying events, and the like. Larger employer groups may also use more than one database for human resources, and those data do not always match up accurately. In the individual market, enrollment errors can also occur when people enter incorrect or inaccurate information.

Provider Use of Enrollment Information to Verify Coverage

It is important to know that the payer is not the only party that depends on accurate enrollment data, providers depend on it too. The most common use of enrollment and eligibility data by providers is verifying that a patient is covered at the time of service. For instance, a hospital will want to confirm that a patient is covered under a health plan so that it can properly bill for its services. If it is not possible for the hospital to verify eligibility (or if the patient is using an ID card for coverage that has lapsed), the facility will make other payment arrangements with the patient. The same may be said for other companies or organizations that are involved in managing benefits; for example, pharmacy benefits managers. Verification of eligibility also typically provides information about applicable member cost-sharing or other potential coverage limitations.

Provider eligibility verification is increasingly handled through automated self-service means. Examples of these types of self-service include secure lookup functions via the Internet, secure direct communications between the payer's and provider's respective IT systems, secure dedicated apps, interactive voice response via the telephone, and use of swipe-card or radio frequency identification technology (sometimes working with established credit card issuers) at the time of service.

Billing

For both insured and self-funded accounts, payment is made before the coverage period begins. Coverage ends if payments are not received, although both employers and individuals have a grace period for reinstatement, meaning the amount of time that past due premiums must be paid in full or eligibility and coverage are retroactively terminated.

Payers bill employers for premiums or administrative fees based on enrolled members and the specific services being provided. For individual coverage, they send bills directly to the individual policy holders, and they typically require individuals to allow for direct billing of a checking or credit card account. As would be expected, billing errors often mirror enrollment errors.

Claims and Benefits Administration

The claims department is responsible for ensuring that, except for applicable member cost-sharing, the network providers are paid directly for the medical goods and services they provide to members, and that members who have paid providers out-of-pocket receive the reimbursement to which they are entitled. Even when providers are capitated, the claims department typically still processes encounters, usually through claims submitted by capitated providers that are counted for purposes of data capture only (these are often called null claims). The complexity of medical claims and benefits administration is almost universally underestimated by those not familiar with health plan operations. Moreover, it is affected by almost every other function in a payer organization. In this section we will take a very high-level look at some of the basic elements of the claims and benefits administration process.

Claims Capture

The first function performed by the claims department is to capture the claim, which means entering a received claim into the claims processing system. All claims are accounted for regardless of how they are received and are assigned unique identifiers. Without logging and entry, claims would be impossible to track. Each major step in the claims process results in an electronic indicator or flag that follows the claim through the system along with its unique identifier.

Claims may come in from a variety of sources, but most commonly arrive through HIPAA-standardized electronic transactions. Claims may also arrive through the U.S. mail, fax, secure e-mail, electronic imaging, and self-entry via the web. They usually come directly from the providers, but when a member receives non-emergency care from a nonparticipating provider and pays for it at the time of service, the member submits a copy of the claim to the payer. Paper claims are scanned using optical character recognition programs that convert them into the standard electronic format. Scanning errors are typically reviewed by personnel (often overseas, working from secure "dumb" terminals) who view an image of the document and correct any obvious problems such as handwriting that the program cannot recognize.

Claims Screening

Captured claims are first screened electronically to ensure that they contain the necessary data and information. Claims that contain all required data are called clean claims and are usually processed quickly. Claims that do not are rejected and returned to the submitter. Scanned claims with missing or incorrect information that could not be corrected by visual inspection are rejected during the review process mentioned above.

Conversion into a Standardized Electronic Record

Claims are converted into electronic records within the payer's processing system for purposes of processing. Some systems use the HIPAA standardized electronic transaction as the basis of the record, but others must convert it into a completely different record format that is a legacy of how their IT system worked before HIPAA. But in any case, a standard claims transaction format should contain various fields required to properly adjudicate the claim, even if some of the fields are only completed during the steps described next.

Basic Benefits Administration

After capturing and converting the claim, the claims system must then go through a series of steps before it either goes through final adjudication (basic benefits administration), or it proceeds on to additional steps before being adjudicated. For clean claims, basic benefits administration is almost always auto-adjudicated, meaning the processing is fully automated with no human intervention.

Well over 80% of all claims are auto-adjudicated on their first pass through the claims system. The rate is higher for claims originally received electronically and lower for paper claims. The reason for this difference is that even after they pass initial screening and are converted to an electronic format, paper claims are more likely to contain other types of errors that do not show up until they are processed.

Determining Coverage

One of the first steps in the basic process is to check the enrollment system to see if the member was covered at the time he or she received medical care. If the member is or was covered, the claim proceeds to the next step. If the member was not covered on the date of service, the claim is denied at that point and the

member and provider are so notified. Rejection for non-coverage is not uncommon.

Determining Benefits Level at the Time of Service

If the member was covered at the time of service, the claims system must then determine which level of benefits to apply. For example, the coverage levels typically differ in POS plans and PPOs for elective in-network care versus out-of-network care, and there are many variations of other types of cost-sharing. Some benefits may be covered in one type of plan but not in another.

Benefit plan designs change over time and members may change the type of plan in which they are enrolled, so the system must determine exactly which coverage was in effect on the date of service. For example, the copayment for a visit to a specialist may have been $30 in December but increased to $40 in January.

The claims system must also determine whether the member has fully or partially met his or her deductible. If not, the claims system applies the appropriate amount against the deductible. The same concept applies to the maximum out-of-pocket costs that an individual or family must pay each year, which the claims system must track because cost sharing stops once that maximum is reached.

Determination of Required Authorization

The system must determine if the medical good or service requires authorization or precertification. If so, it looks for a record that such preapproval was obtained, which typically exists in a separate medical management system or module. If there is no such record, the claims system must determine if the service was elective or an emergency: Emergency services are covered at the in-network level, whereas there is less coverage, or no coverage in some cases, for non-authorized elective services. This can occasionally be a difficult determination to program into a claims system, and some of these claims may instead be pended to obtain additional information (described shortly). Another example is disallowment of a duplicate claim.

Applying the Correct Provider Payment at the Time of Service

Once a claim is determined to be covered to any extent, the claims system must determine the correct amount to pay (or apply against cost sharing) for each submitted claim, based on its diagnostic and procedure codes, and payment schedule applicable to a specific provider at the time of service. Payment terms and amounts often vary between different types of products (e.g., HMO and PPO products offered by the same payer), payment amounts may change each year for the same type of product or may change entirely from year to year. Payment amounts also often differ by network requirements such as a special fee schedule negotiated by a large medical group or hospital system. In fact, the claims system must be able to handle all of the different payment methods described in Chapter 4 if they are used by the payer.

Payment may include disallowment of some part of a claim, meaning some charges are disallowed and a participating provider may not bill for them. Many providers of all types unbundle their claims, meaning they include charges under billing codes for services that are supposed to be paid through one payment. For example, an outpatient facility may include separate charges for gauze dressings, sutures, and other supplies; and a hospital with employed physicians may tack on a facility fee for routine office visits, something that the basic office visit fee is supposed to include. The system must determine when unbundled or add-on charges are inappropriate and not payable, and when they must be covered. Another example is disallowment of a duplicate claim.

Application of Routine Medical Payment Policies

Routine medical payment policies are rules for using clinical information to make commonplace claims payment determinations. For example, one common medical payment policy is to pay an assistant surgeon no more than 50% of the fee that the primary surgeon receives. Another common policy is to pay for only one abdominal surgical procedure even if a surgeon bills for multiple procedures performed at the same time. Most routine medical policies are fully integrated into the basic claims adjudication system and are applied on an automated basis.

Management of Pended Claims and Adjustments

Up to this point, everything except claims capture involving paper claims is nearly always automated, involving very little, if any human intervention. That is not the case for most pended claims or adjustments. The cost to payers for fully automated claims processing is quite low on a per-claim basis, but high when plan personnel must be involved. For that reason, payers strive to see that as many claims as possible are auto-adjudicated and free of errors. But it is not possible to auto-adjudicate 100% of received claims.

A claim is usually pended by the claims system, which means that it is neither paid nor denied, but rather put on hold so further information can be obtained. When a claim is pended, the claims department must have a system in place to make sure that the claim does not wind up in limbo. The department needs to track each pended claim and make sure that timely action is taken on those claims.

A claim might be pended for any number of reasons. For example, there may be a diagnosis-procedure mismatch, which means just what it sounds like. In such a discrepancy, claims systems typically automatically generate a notice to a contracted provider about the problem and request the claim be resubmitted with the correct codes or additional information. Claims that require manual review and determination based on medical necessity are also first pended before being forwarded to the appropriate clinical personnel in the plan.

Paid claims may sometimes be reopened for adjustments. This occurs when a claim is processed but then an error is corrected, or additional information is provided, resulting in a change to the coverage and/or payment amount. Adjustments almost always begin with a communication from a member or provider to the payer. Adjustments may also occur after a member successfully appeals a benefits coverage denial.

Finally, a claim may be pended or even reopened to determine whether another party is responsible for paying all or part of the claim, which is the next thing we will look at.

Coordination of Benefits, Other Party Liability, and Subrogation

There are three situations in which another party has primary responsibility for payment of all or part of a medical claim. It is the responsibility of the claims department to identify and handle these situations so that the plan does not pay when another organization is obligated to pay first. This can be automated in many cases, but not always.

Coordination of Benefits

The most common situation in which another party has responsibility for payment of a claim is called COB. This happens when an individual is covered by two or more health plans, such as when two working parents each have employment-related health benefits. If both parents elected family coverage, then their children are covered by both benefits plans. Another example is when an individual with Medicare also has coverage from a private plan other than an MA plan.

COB is the process for determining which coverage pays first, and which pays second.

There are many other situations in which COB is involved, and payers usually follow a complex set of rules in determining which health plan has primary payment responsibility and which one is secondary. Benefits from both policies may also be available under certain circumstances.

Other Party Liability

Other party liability (OPL) means that some other type of insurance may be liable for all or part of the healthcare costs incurred, such as automobile insurance or worker's compensation. When the other coverage has benefit maximums or limitations, the health benefits plan may then become responsible once the other insurance no longer covers costs.*

Subrogation

Subrogation refers to the right of the payer to recover any money it paid for medical costs that were also paid by another party with the primary responsibility, or where the medical costs were caused by another party. A common example is a legal settlement or award that is calculated based on a combination of lost income, medical costs, and pain and suffering; the payer can sue to recover that portion of the award that was based on medical costs that the plan has already paid. Another example is a payer suing a company whose negligence resulted in traumatic injury to a member. Subrogation is required in some states but is illegal in others.

Management of Claims Inventory

Claims inventory refers to the number of claims that have been received but not yet processed. Claims are rarely processed immediately upon delivery, and a typical inventory level is somewhere between 7 and 14 days' worth of claims, though that can vary quite a bit. Plans typically establish a policy regarding inventory levels: If the length of time it takes for routine processing exceeds that level, a claims backlog is said to exist. Claims that have been pended do not usually count as part of the backlog. Most states, as well as large employers, also have standards for how quickly a clean claim must be paid, generally referred to as timely payment.

A backlog can arise if claims productivity drops or if too many errors occur at any of the various places where the claims system depends on accurate data. Backlogs can generate problems throughout the plan. For example, providers and members will become unhappy, leading to more work for the member services and network management departments. Claims backlogs are associated with an increase in processing errors as the claims department tries to dig its way out. In addition, such backlogs may result in providers submitting duplicate claims in the belief that the original claims were lost, adding to the volume of claims and worsening the backlog, and increasing the number of payment errors including duplicate provider payments that must then be recovered. Managing and correcting errors in coverage and payment caused by a backlog requires costly manual interventions.

Finally, a claims backlog reduces the accuracy of calculating reserves, or the amount of money that must be available to pay the claims that will eventually be processed. This can potentially lead to a very dangerous condition, as we will see later in the chapter when discussing financial management.

Payment, Explanation of Benefits Statements, and Remittance Advices

Final adjudication does not mean instant payments. Once a claim has been approved and finalized, it is routed to the accounts payable

* Technically this is a form of COB; indeed, some sources refer to both COB and OPL as one or the other, but it is more accurate to separate the two.

function in the system, which has its processes that take a certain amount of time to complete. Most payments to network providers are through EFT or by mail. The provider is also sent a notification of payment or remittance advice, providing relevant information about how the claim was processed, the amount(s) paid by the payer organization, and the amount that the patient is responsible for paying.

When a member is reimbursed for covered care from a noncontracted provider, the member is usually sent a paper check for the amount covered, and he or she is responsible for paying the provider. Some noncontracted providers send in the claim to the payer after asking the patient to sign an assignment of benefits form, in which the provider and the patient ask the payer to send the check directly to the provider rather than to the subscriber. Most payers refuse to assign benefits to a nonparticipating provider, because direct payment is one of the benefits of participation for a provider. Some states, however, require plans to direct payments to nonparticipating providers if the member signed the form.

Payers also send an explanation of benefits (EOB) statement to the subscriber (even if a dependent received the care) that describes what was covered, what was not covered (if anything), what adjustments were made and why for each code, how much the plan paid, and how much the subscriber is responsible to pay. The EOB also informs the subscriber of the right to appeal coverage denials and explains how to do so.

Archiving

The final step in the claims management process entails storing all the information about each claim, from its initial submission up through final adjudication and any post-processing adjustments. These records are important in cases of appeals and grievances for reconciling self-funded accounts, for retrospective review, for audits, for analysis, in the event of a lawsuit, or other needs that may arise. The data and information are stored electronically, including electronic images of paper documents (the actual paper documents are stored separately). How long records are stored is usually dictated by any applicable laws or regulations limiting the length of time that the payer may be audited or the subject of a lawsuit. This span can vary but typically ranges from 7 to 10 years.

Fraud, Waste, and Abuse

Fraud, waste, and abuse are often combined as a concept,* but they are different, though there is some overlap between fraud and abuse. When fraud or abuse are suspected or detected, both are usually handled by a payer's Special Investigations Unit (SIU) or a similarly named department. Waste is usually lumped in with abuse but is also one of the reasons for managed care's payment and utilization processes in the first place. In this section, we will address only fraud and abuse.

Healthcare Fraud

Healthcare fraud is a type of crime in which dishonest or false claims are filed with a payer. Examples of healthcare fraud include, but are not limited to:

- Filing a claim for a service or good that was never provided
- Altering dates, codes, or identifiers to obtain payment more than once
- Forging a signature or record
- Paying or receiving kickbacks
- Billing for services provided by unlicensed providers

* Often in the form of what could be a single word: "Fraudwasteandabuse."

- Medical identity theft
- Obtaining a prescription and then selling it to someone else
- Renting or loaning out a member ID card to someone not entitled to coverage

There are several ways payers may detect suspected fraud. Most claims systems have some high-level programmed logic that looks for billing patterns that are sometimes seen with large-scale fraud. But there are other ways that in which a payer may become aware of possible healthcare fraud; for example:

- Actions taken by a state's Board of Medicine
- Actions reported to the National Practitioner Databank or the related Healthcare Integrity and Protection Data Bank
- Contact from a federal or state official, including law enforcement or regulatory agency
- An individual providing information, a so-called "whistle blower" or an informant
- Concerns raised by a network provider or providers
- A high number of similar member complaints
- News articles or articles in the trade press
- Direct communications from another payer about potential fraud and abuse.

Unfortunately, those that commit large-scale fraud are often adept at avoiding easy detection. When healthcare fraud is committed, it is usually by a non-network provider or somebody who is pretending to be one, but not always. In some cases, the level of fraud is very large and done by organized criminals. Internal fraud committed by an employee of the payer, or a plan member, does happen, but less often.

Unlike with abuse, when a payer is reasonably sure that fraud has occurred, they typically involve the appropriate law enforcement agency, and regulatory agency if appropriate, before taking any further steps so as not to interfere with how the agency may want to proceed. This includes taking no actions that might alert the person or organization suspected of billing fraud that could cause them to destroy evidence and records, or even flee.

In some cases, law enforcement may determine that the level of the crime may not be worth the use of their limited resources and leave matters up to the payer. Payers may then file a lawsuit. If a network provider is involved, they are terminated from the plan for cause; if a member commits fraud, their coverage is terminated immediately or even retroactively. Finally, proven provider fraud is reportable to the federal Health Care Integrity Database (see Chapter 3).

Abuse

Healthcare abuse in the payer industry refers to abusive billing practices that may—or may not—fall short of outright fraud. Many in the industry consider abusive billing to be a form of fraud, and it may be hard to draw a clear distinction in some cases.

Examples of common forms of abusive billing include, but are not limited to:

- Inflated or inappropriate charges
- Upcoding, meaning submitting claims using a billing code indicating a more expensive service than was performed
- Unbundling charges to include items or services that are supposed to be included in the fee
- Provider self-referral (see Chapter 5)
- Providing more treatment than is medically warranted

Abusive billing may be detected through claims data analysis and provider payment and practice patterns. But these can only be found if the payer's IT system is programmed to look for them, and that usually requires some focus. It is not practical for a payer to be able to detect all abusive bills, or fraudulent bills for that matter, and the levels of abuse can vary as well. Generally speaking, the most productive means of detection are looking for spikes in costs, particularly if they are associated with certain providers and are consistent.

Special Investigation Unit

Most payers have an SIU that specializes in analyzing and investigating suspected fraud and abusive billing. An SIU does not have unlimited resources or an army of trained personnel, so it typically focuses on situations where the amount of money exceeds a threshold, though that will differ from plan to plan.

Member Services

Member services act as the interface between members and a payer. In other words, when an individual member has a problem or needs assistance, the member services department helps the member handle it. Interactions between members and member services may occur on the telephone; via secure e-mail; through secure, live web-enabled chat; by correspondence sent via U.S. mail (or any other document delivery service); or face to face in a customer service center.

Assisting members may be at the top of the list of responsibilities of member services, but the department does more than that, and a more representative list of overlapping functions would include:

- Assisting members with problems or complaints
- Providing information to members
- Undertaking proactive member outreach
- Monitoring member satisfaction and conducting member surveys
- Managing the formal grievances and appeals processes

Member services may be outsourced to help reduce the pressure on the department, particularly during periods of heavy new enrollment, and there exist companies that specialize in this. This form of temporary outsourcing usually requires focused training and support, and limits are placed on what can be done. Because member services must be able to accommodate differences in cultural and language if the payer's members are diverse, payer employees may be able to handle some commonly used languages such as Spanish but may contract with a company to add a capability for significantly more.

Assisting Members with Problems or Complaints

Member problems can range from something as simple as an incorrect identification card to something as complex as a mishandled claim for medical expenses. HMOs and POS plans have a special interest in helping members select physicians and straightening out problems with authorization and other unique aspects of managed care.

Complaints can vary widely but are considered to be informal. Formal complaints take the form of grievances or appeals of coverage denials, which are addressed later in this section. A complaint can progress to a formal grievance or appeal, but most do not. Complaints often focus on coverage or payment policies and deal with issues too such as an error in enrollment or claims processing, misspelled names, difficulties with getting an appointment, and so forth. Many are resolved quickly, but some take more time.

This aspect of member services can be one of the most stressful roles in a payer organization, so member services representatives undergo specific training to help them manage this role in a professional manner. Also, more complex complaints or particularly upset members are often referred to the more experienced member services representatives.

Providing Information

A health plan must regularly communicate with its members. Such communication begins before enrollment, when the plan provides information through the SBC and other marketing materials, and it continues for as long as the member is covered (and often beyond that, too). Examples of routine types of communications can include keeping members informed about any significant changes in the network, ways to obtain assistance, help with

understanding benefits, and so forth. Member services may also help coordinate or conduct member informational sessions.

Some types of communications are required by law or regulation. Examples include the SBC and providing or making the EOC available upon request, extension of coverage rights, privacy and confidentiality rights, and denial of coverage appeal and grievance rights (which are also communicated to members in the SBC, the EOC, and the EOB) that are discussed later in the chapter.

Proactive Member Outreach

Proactively reaching out to members can have a positive impact on member satisfaction and on the operations of the payer, particularly for smaller plans and closed panel HMOs (Chapter 2). For instance, a welcoming call to new members can help them understand how the payer operates, help with physician selection in an HMO, answer any questions they have, and take care of any issues that may have already arisen. Contacting members who have not extensively used the payer's services is one way to make sure that they are satisfied with their membership.

Outreach by member services representatives is costly, however. Recently, under the pressure of the ACA's MLR limits, many plans have adopted automated electronic systems and so-called push email or text messages to provide information and to encourage members to use the plan's self-service resources.

Monitoring Member Satisfaction and Conducting Member Surveys

A payer must continually gauge the level of member satisfaction. Periodic surveys can allow the payer to discover how members view their health plans and pick up on trends at an early stage. A survey may contain general questions intended to expose the overall level of satisfaction with the payer, or it may contain narrow questions targeted at specific issues, such as the adequacy of the provider network. In some cases, specific types of member satisfaction surveys are required, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS; see Chapter 5). Further, states and some accreditation programs require payers to conduct broad member satisfaction surveys, including CAHPS, and act on the results.

Formal Grievances and Appeals

Grievances and appeals are two different types of formal notifications by members that require formal responses from health plans. A grievance is a formal complaint about anything other than a coverage denial, such as a formal complaint about a quality of care issue or about an interaction between the member and the plan. An appeal is a formal request for an additional review of a denial of coverage determination. In both cases, a written response is required according to various schedules, but the processes for handling complaints and appeals differs. Note that grievances and appeals apply only to members, not to providers, although providers frequently become involved in the process on behalf of their patients.*

Managing the appeals and grievances processes is typically the responsibility of the member services department, though other departments may be heavily involved too. The volume of formal appeals and grievances is very low compared to all interactions between plans and members, but its importance is very high and comes with regulatory requirements and reporting. Managing this process is a support function that requires timely correspondence between involved parties, obtaining information, maintaining records, and keeping the process on track.

* There are other appeal rights as well. A provider excluded from a payer's network may appeal the decision, and consumers denied coverage through an exchange also have appeal rights. Neither is the same as member appeal rights discussed here.

Grievances

A grievance is a formal complaint, demanding resolution or a formal response. It may come directly to the payer, but more often is submitted through a regulatory agency such as a state insurance department or CMS. If the member belongs to a self-funded benefits plan, the grievance will usually come from or through the employer.

Examples of grievances include a formal letter or email from a member to the insurance department; for example, alleging that an insurer has improper sales and marketing practices. A member in an MA plan may write to CMS complaining about poor service. In each case, the involved agency requires a response from the plan and, if it deems this step to be necessary, may investigate further. A pattern of grievances or particularly egregious acts may lead to fines or restrictions on operations or sales, and a pattern of serious problems can lead to disbarment from the MA or managed Medicaid program or even revocation of licensure.

Appeals of Denials of Coverage

Members are informed of their appeal rights on the SBC, on the EOC, on all EOB statements, and on a payer's website (though it may take some navigating to find it). In addition to specifying what these rights are, it provides information necessary for members to begin the appeals process, tells them what documents a member may submit for consideration, and points members to resources where they can find more information.

Appeal rights are governed by the ACA as well as ERISA for self-funded benefits plans. Most states also have laws providing appeal rights to individuals covered through insured plans. State laws and regulations can be more stringent than what is required under the ACA, but not less; if a state does have less stringent laws, then the federal government will handle the process as needed.

A denial of benefits coverage can apply to any point where coverage determinations are made, ranging from precertification denials for care not yet provided, to concurrent denials of a continued hospital stay, to denials of coverage after the care has been provided. An appeal of a coverage denial may begin with an informal review request, which does not start the clock on timely response. If the issue is resolved at that point, it does not become a formal appeal. If an informal review does not resolve it, then the member has the right to proceed to a formal process. An appeal can also begin with the formal process, and a member can request that both the internal and external appeals processes take place at the same time.

For a formal appeal of a coverage denial, the internal physician review process is done by a health plan physician or physician committee that includes a physician of the same or a similar specialty as appropriate, and who were not involved in the initial decision. Payers often ask network physicians to participate on an as-needed basis. If the denial is overturned, the decision is binding on the plan.

The external physician review is performed through one of two or three independent review organizations (IROs) under contract with the state or federal government that is randomly assigned the case. Physician review is done by a physician of an appropriate specialty. Whatever decision is made by the IRO physician is binding on the plan and the member.

During the appeal process, the plan's documented coverage policies and EOC document, as well as its definition(s) of medical necessity in the EOC document, are important for all reviewers to understand. Additional documentation sent in by the member or the member's physician(s), notes by UM nurses or member services representatives, or other relevant information must be available as well. Only the relevant portions of any records, including a member's medical records, are required, however.

The main elements of the appeals processes provided under the ACA and ERISA are summarized in **TABLE 6.5** for internal reviews, and in **TABLE 6.6** for external reviews.

TABLE 6.5 Main Elements of the Internal Review Process for Appeals of Coverage Denials

- A member must file the appeal within 180 days of being notified of the denial.
- If the member requests it, the plan must provide the member with copies of documents that are relevant to the claim, and identify any medical experts involved in the review.
- The member and/or the member's physician or other provider may submit additional information if they wish.
- The appeal must be reviewed by someone who looks at all of the information submitted and consults with qualified medical professionals if a medical judgement is involved.
  - This reviewer cannot have been involved with the initial decision or be a subordinate of the person who made the initial decision.
  - The reviewer must give no consideration to the initial decision.
- After an appeal request is received, it must be reviewed within defined time periods:
  - If the appeal is urgent (based on the medical needs of the member), it must be reviewed within 72 hours.
  - Preauthorization appeals must be reviewed within 30 days.
  - Appeals for coverage after a service has already been provided must be reviewed within 60 days.
- If the reviewer overturns the denial, the decision is binding on the plan, but the member can still request an external review.
- An individual may obtain an independent external review of a denial appeal and must be allowed to file for it no less than 4 months following notification of the upheld denial.

Data from 26 CFR Parts 54 and 602, 29 CFR Part 2590, and 45 CFR Part 147 in the Federal Register, Vol. 75, No. 141.

TABLE 6.6 Main Elements of the External Review Process for Appeals of Coverage Denials

- An individual must request an external review within 120 days of being notified that the denial was upheld by the internal reviewer(s).
- The cost to the member for an external review request cannot exceed $25.
- External reviews must be conducted by an accredited IRO selected on a random basis by the state or the federal government.
- Reviews will be conducted by clinical personnel with the appropriate training and education relevant to the type of coverage denial.
- The plan must provide relevant documentation to the reviewer within 5 days of notifying the IRO. It must include material related to any internal review, but only as information, and the reviewer must give no consideration to the initial decision.
- The member may provide additional information, and/or the reviewer may request additional information.
- If the reviewer concludes that the request is not eligible for external review, the reviewer will notify the parties; otherwise, the review will proceed.
- After an external review request is received, the IRO review must be completed within the defined time periods.
- An expedited external review for an urgent case must be decided within 72 hours.
- A standard external review must be completed within 45 days.
- The decision by the IRO is binding on both the plan and on the member.

Data from 26 CFR Parts 54 and 602, 29 CFR Part 2590, and 45 CFR Part 147 in the Federal Register, Vol. 75, No. 141.

The percentage of appeals that result in a denial being overturned is still being studied by the government at the time of publication, but earlier studies showed that between one third and one half of all appeals resulted in overturned denials.

Financial Management

The finance department is responsible for managing the payer's money. It has four main areas of responsibility:

- Operational finance
- Treasury management
- Budgeting
- Reporting

Before addressing these four broad responsibilities, it is worth looking at three important accounting concepts as they apply to payers.

Three Important Accounting Concepts

Accounting is well beyond the scope of this text, there are three important accounting concepts to understand. What follows is a very simplistic and high-level description of these concepts; the realities are much, much more complex.

Accrual Accounting

There are two ways to approach financial accounting: cash accounting and accrual accounting. This distinction is not unique to the insurance industry, and most companies other than very small ones use accrual accounting. Cash accounting means that all of the financial numbers are based on the actual movement of cash, as currency, deposits, bill payments, and so forth. This method is what most of us use to manage our personal finances. It is not suitable for financial management of a large company, however, and is especially unsuitable for a payer.

Accrual accounting means accounting not only for cash, but also for money that will be received and will be paid.* It includes known amounts, such as the payroll or payments that will be received, as well as estimates of amounts not yet known. For a health insurer or HMO, the most important of these estimates is how much will be needed to pay claims on its insured business, even if the payer does not actually know what those claims will be. Those estimates are used to accrue money (meaning, in this case, put money aside) as a reserve to be used to pay the claims as they come in. So even though the payer has this money, it is considered a liability, not an asset because it must be used to pay claims. We will revisit this topic shortly when we look at calculating claims and reserves for incurred but not reported (IBNR) claims.

Statutory Accounting Principles and Statutory Net Worth

Almost all companies use Generally Accepted Accounting Principles (GAAP)—a set of standards, rules, and definitions that provide for uniform financial reporting—in their accounting practices, annual reports and so forth. Payers use GAAP as well, but they must also use another set of accounting standards, though only with their insured business: Statutory Accounting Principles (SAP). SAP is used by regulators as part of their financial oversight responsibilities, which accounts for the "S" in SAP. GAAP and SAP differ most importantly in how they define what counts as an asset.

A company's net worth is made up of its assets minus its liabilities. But net worth is defined differently under SAP, and for that reason is called statutory net worth. All states have laws and regulations defining the minimum

* Technically it means measuring the performance and position of a company by recognizing economic events regardless of when cash transactions take place, to better understand the company's financial state.

statutory net worth required of a payer for its insured, meaning at-risk, business. SAP does not apply to self-funded benefits plans. States can differ in how they define assets and liabilities under SAP, but most follow guidance issued by the National Association of Insurance Commissioners.

Under SAP, an asset is defined by state insurance laws and regulations, and it comprises the amount of cash or readily available money, meaning cash or liquid investments that are considered cash-equivalent, that a plan is required to have on hand at all times. Unlike GAAP, SAP places a limit on how much value may be placed on nonliquid assets such as computers, buildings, nonconvertible long-term investments, and so forth, limiting this value to no more than 5% of total statutory assets.

States require plans to have assets that are higher than the amount the payer expects to use to pay claims for at-risk business and other liabilities. The amount above expected liabilities is called statutory surplus or statutory capital. A payer cannot use statutory surplus for anything if doing so lowers the payer's statutory net worth to anywhere close to the minimum required amount. The least amount of excess cash or cash-equivalent money that a plan must have on hand to meet its minimum statutory net worth requirement is established by the state, but the minimum is usually enough to continue to pay claims for at least 3 months without any additional premium or income. States typically expect payers to have much more than that amount available, though, and regulators will usually take action if the amount of statutory capital begins to approach the minimum.

Because minimum statutory net worth requirements are only for insured, or risk-based business, HMOs that have transferred some risk to the providers through capitation may have lower minimum requirements compared to a plan that does not use risk-based provider payment (Chapter 4), though it does not completely offset it. How much the statutory net worth is affected by self-funded business, provider risk sharing, and some other conditions is known as risk-based capital and it is determined by specific accounting rules and definitions.

Claims Reserves and Incurred But Not Reported Claims Reserves

As noted already, claims reserves are a liability, not an asset. That is because the claims reserves are what the payer estimates will be used in the normal course of business to pay claims for any given period of time.

Claims reserves are made up of two parts: (1) the amount of money in known claims and (2) the amount of money the plan estimates will be needed to pay claims for medical services have been provided but claims have not yet been submitted, which is called IBNR. This is a critical concept. If a plan determines its total claims liabilities by counting only claims that it has paid or that are in its system, then it will not set aside enough money to pay all the claims that have yet to come in and for which premium has already been paid. Said another way, premium payments are steady and come in before claims are incurred, but claims come in all sizes and amounts, and arrive much later. Failing to appreciate and account for this difference in timing has been the demise of many smaller health plans and provider-owned plans, and some plans that experienced rapid growth.

Each month's IBNR is calculated, reserved for, and tracked separately. As claims for medical care provided in that same month come in and are paid, the reserves for that month are reduced by the amount paid out. Claims can take a long time to straggle in, so most payers calculated reserve estimates that last for 12–18 months, with anticipated claims payments steadily dropping off over that time. Timely filing terms in provider contracts help in this regard but have less effect on claims from noncontracted providers.

The estimated IBNR is more than an educated guess. It is calculated monthly using a combination of data, including enrollment data for insured business, benefits levels and cost-sharing data, actual versus expected volume of claims received that month, actual versus expected claims inventory, seasonal and regional utilization trends, pricing trends, historical trends, and more. By tracking each month separately, these data are more effectively used, and the plan can monitor how accurate its IBNR calculations were and make adjustments to its reserves as needed.

Operational Finance

Operational finance refers to the day-to-day functions of the finance department. The most important of these functions is tracking all money that comes in and goes out. Broadly speaking, the following categories are tracked:

- Revenues, including premiums for insured business, administrative fees for self-funded business, and other revenues (e.g., from subsidiaries)
- Costs, including medical costs (both paid and estimated) for its insured business, administrative costs, and other fees and costs
- Surplus and reserves
- The bottom line, before and after taxes

Treasury Management

Treasury management refers to managing cash and short-term investments. It also usually, but not always, refers to managing long-term investments. Payers generally have a lot of cash on hand for both operational claims reserves and for statutory reserves, but also because premiums and fees are paid before the fact, whereas claims and services occur after those payments have been received. Managing such a large amount of cash to keep it safe and, when possible, earn some investment income is an important element in managing finances overall. Cash that is counted towards meeting statutory reserves can only be invested in certain ways because long-term investments or investments other than low-risk ones may not meet SAP standards for liquidity.

Budgeting

All organizations require a budget to properly manage their operations, and payer organizations are no different. What makes budgeting for a payer unique is the need to create one budget for medical expenses and a separate budget for operational expenses. Further, different financial tools and techniques are used to create the two budgets. Budgeting is essential, for it is only through this process that the payer can test assumptions about how much to charge in premiums, how much it can or cannot spend on administration, how much it can afford to invest in administrative improvements, and how much profit (in for-profit companies) or contributions to reserves (in nonprofit companies*) will be earned.

Reporting

The finance department must do several types of reporting, though some payers have a separate department for report filing. Specifically, the finance department is usually responsible for creating reports for each employer customer, the state insurance department(s), the state health department(s) in states that require it, DHHS and CMS, the U.S. Department of the Treasury and Internal Revenue Service, the U.S. Securities and Exchange Commission (if it is publicly traded), the U.S. Department of

* NB: It is common for nonprofit healthcare companies, including nonprofit or non-investor owned health insurers and HMOs, to have for-profit subsidiaries that may also be a type of payer. In this way, the subsidiary can transfer its profit to the parent organization.

Labor, and the state Medicaid agency (if the plan participates in that program). All of these reports use special types of forms, though state financial filings use forms called "blanks."

A separate independent form of financial reporting known as internal auditing frequently resides in the finance department but may operate autonomously. It is responsible for ensuring that all areas of the payer are both reporting accurate numbers and operating according to the company's policies and guidelines.

An insurer is a "domestic" insurer in the state in which it is incorporated and where it was issued its primary license; it is a "foreign" insurer in other states in which it obtains an insurance license to operate. For purposes of filing financial reports, states rely on the state of domicile to be the primary regulator of a multistate insurer, though each state still requires foreign insurers to obtain a license, to comply with the state's laws and regulations, and to file copies of financial reports.

Unlike insurers, HMOs are incorporated, licensed, and regulated separately in each state in which they do business, even if they are a subsidiary of a larger company, and states do not rely on a state of domicile. HMOs therefore file separate reports for each state they do business in.

Finally, the finance department is responsible for maintaining the organization's financial records in such a manner as to be considered acceptable to an independent certified public audit firm for purposes of an audit. For-profit plans must have the CEO attest to the accuracy of the financial statements.

Operational Challenges in the Payer Industry

The last major topic to address in this chapter is to identify some of the more common problems and challenges specific to the payer industry. To be sure, none of the challenges and their causes that follow happen in all, or even most, circumstances, and all may be avoided or successfully managed. But they are all real and have all occurred in different payers at different times. Some of these challenges have already been described earlier in the chapter, but are included here for emphasis.

We will look first at potential challenges that are common to any payer, followed by looking at some that are specific to provider-owned or sponsored payers. Challenges that any business may face are not addressed. The two major payer-centric areas not included here are provider payment and medical management, which have chapters of their own that include some discussion of potential challenges.

Operational Challenges Applicable to Any Payer

Operational challenges applicable to any payer are related to the important administrative and financial functions described in the rest of this chapter. Not surprisingly, they are interrelated, meaning they usually do not occur in a vacuum and can cascade from one problem to another. Here we look briefly at four of them:

1. Undercapitalization
2. Problems with statutory capital
3. Incorrect and insufficient IBNR calculations
4. Challenges associated with rapid growth.

The first two may even be thought of as one, but there are some subtle differences worth pointing out. The fourth is a special circumstance that can lead to the first three.

Undercapitalization

A health insurer or HMO requires a great deal of capital, and not only to pay for operations. As we have already seen, a plan must have far more than the minimal amount of required capital to operate safely, and it doesn't take a

lot of financial losses for a small plan to deplete its capital to the level where the state imposes sanctions or even declares it impaired or insolvent, which is the ultimate failure for any plan.

Undercapitalization is addressed here in the context of situations when not enough capital is paid into a company to allow it to weather the inevitable ups and downs of the industry. It disproportionately affects smaller plans because they typically have less capital on hand.

In any payer, the primary source for operating funds comes from earning a positive financial margin. But making a profit is no easy matter, and because healthcare costs—and premiums—are so high, a few percentage points of margin loss represents a large number of dollars. To make things even more difficult, recall that the ACA's strict MLR limits restricts how much profit or positive margin an insurer can make or keep for its insured business, and prohibits an insurer from trying to subsidize losses from medical costs in future premiums.

Both nonprofit and for-profit plans can experience undercapitalization, but nonprofits usually have fewer sources to access capital. For example, for-profit plans, including subsidiaries of a nonprofit company, may seek additional paid-in capital from a parent company, or by selling additional equity to investors.

Both nonprofit and for-profit plans may also sell bonds, though nonprofits have more flexibility to offer types of bonds with favorable tax treatment. Nonprofits may also qualify for types of governmental support, though that option has seriously declined in recent years. Payers can also access capital through certain types of debt and a few other means that are beyond the scope of this text to describe, most of which can place considerable burdens on the company.

Finally, a payer struggling with undercapitalization may attempt to merge with or be acquired by another company. Nonprofit plans may be acquired by another nonprofit company, but to be acquired by a for-profit company the nonprofit must first convert.

Statutory Reserves or Statutory Capital

As described earlier in the section on financial management, as well as referenced in the preceding subsection, health plans must maintain a minimum level of capital in unused reserves for its insured business. What statutory reserves are and how SAP works was described earlier and that will not be repeated here. The dollar amount depends on the number of insured members, the amount of premium, and the amount of financial risk. When statutory reserves approach the minimum requirement, the state may impose sanctions, restrict marketing, or place stiff reporting and operating requirements on the payer. When they fall below the required amount of statutory reserves, payers are declared impaired by the Department of Insurance and may be put into receivership.

Incorrect and Insufficient IBNR Calculations

IBNR, as described earlier, is the amount of money that must be reserved for medical services that have been provided, but for which claims have not yet been received by the plan. Insufficient IBNR calculations are one of the most common problems incurred by new and/or growing health plans.

If a plan's financial managers are not thoroughly familiar with how to compute an IBNR (or its actuaries are not vigilant), it is nearly inevitable that it will be done dangerously wrong. One of the most common mistakes made by inexperienced financial managers, and which was also described earlier, is to just add up the claims that came in for the month and assume it represents the month's entire claims liability. Another common source of error is using a lag period that is too short and

does not include claims liabilities that come in after that period. A third common source of IBNR error is related to rapid growth, as described next. A fourth source of error, one that is much darker because it can be deliberate, is when a plan is incurring losses in the face of little available capital, so managers use an overly-optimistic amount of IBNR to avoid tying up even more capital.

Experienced financial managers know how properly to use lag tables, monitor and adjust reserves as necessary, and to be conservative with IBNR, meaning increasing the amount of reserves in any situation that can raise the risk of error.

Rapid Growth

All business must grow to thrive or even survive. But growth can be too rapid. Rapid growth in a small health plan quickly overwhelms everything: IT systems; accounting, statutory reserves and IBNR calculations; member and provider services; provider payment. Everything. It creates claims processing backlogs that result in duplicate payments, payment for care provided to members no longer covered by the plan, and so forth. After chronic losses, rapid growth is one of the most dangerous times a small or new health plan experiences. While problems related to rapid growth also appear rapidly, unlike chronic losses, they appear some months after the growth surge and can take a long time to resolve.

Operational Challenges Specific to Hospital-Owned Health Plans

The second major category of potential problems and challenges is about provider-owned or sponsored health plans, which we will refer to from now on simply as hospital-owned for the sake of brevity. There are some notable examples of plans owned or sponsored by a large medical group, but there are fewer of those, so this section focuses only on plans owned by hospitals or health systems.

Recall from Chapter 3 in the section on integrated delivery systems (IDSs) that many of the IDSs that took on risk for medical costs had a poor outcome, and the same applied to hospital-owned health plans at that time. Some of the more common interrelated causes included:

- A lack of managed care-specific management experience by hospital executives and physicians
- Conflicting organizational financial incentives from being paid mostly through FFS or other traditional means that rewarded higher—not lower—utilization and prices
- Conflicting personal incentives as executives at hospitals tried to maximize bed-days and revenue, while executives at the IDS's payer organization or health plan tried to reduce them with only tepid internal support
- Independent physicians' perception of the IDS or hospital-owned plan as a means of reducing what they perceived as HMO interference, resulting in higher utilization
- A lack of understanding about how to manage, or even account for, financial risk
- Adverse selection from enrolling a higher than normal percentage of people who were familiar with the IDS because they had serious chronic illnesses
- Hospital executives and physicians thinking of members as patients, when to succeed a health plan must have members that do not have serious medical problems and are rarely, if ever, patients

Hospital-owned plans—and risk-taking IDSs for that matter—may face similar challenges today, but should have a better chance of success for the following reasons:

- Hospital and health systems are much larger now, allowing them to market their services more broadly

- There are more executives with payer experience that a hospital-owned plan can bring in
- IT and other support systems are much better
- At least some of the consulting and professional services companies have good capabilities, though not all do
- UM support tools and general knowledge have improved considerably, and health systems are more used to managed care
- Health systems with a large panel of employed PCPs and specialists can function like a group- or staff-model HMO, as long as they have strong and experienced physician leadership

Unique problems and challenges facing hospital-owned health plans nevertheless remain, and that can offset the reasons why hospital-owned plans have a better chance of succeeding. These are addressed in five interrelated broad categories:

- Conflicting Incentives
- Underestimating the Value of Plan Operations;
- Economies of Scale
- Financial Management of Risk
- Adverse Selection

Conflicting Incentives

Regardless of what may be said publicly, and in some cases even believed, many health systems create and run health plans to fill beds and increase utilization of their ambulatory and diagnostic facility services. But the health plan's goal is exactly the opposite. The health system can internalize this conflict, with executives responsible for the health plan focused on keeping costs under control having a completely different focus from those running the rest of the system. As has been emphasized earlier in the book, what is cost to one party is revenue to another. What executives running the hospital-owned health plan sees as achieving cost control, executives responsible for running clinical services see as cutting their revenue.

At its most fundamental, executives and managers all throughout the system, not just at the top, will strive to meet their performance goals. To do otherwise results in less compensation than does meeting them, and lower chances of promotion. The executive at the top also has a conflict because most hospital CEOs achieve personal compensation increases and bonuses for achieving volume and growth, not for reducing revenues; revenue reductions resulting from the CEO's strategy may lead to the exit door.

This fundamental incentive applies to physicians too, whose personal compensation is usually related in some measure to productivity, meaning how many patients are seen each day. If most of the revenue related to physician activity comes from external sources and is not based on risk, performance goals will be related to that as well and behavior will be influenced accordingly.

Performance goals, incentives, and personal compensation affects nearly all executives and managers throughout a health system. Managers rewarded for growing volume and profitable revenue for a clinical service will do just that, and the hospital's owned health plan is just another source of revenue. Either that or a huge irritant threatening the manager's bonus. In most cases, cooperation will be less than enthusiastic, particularly when hospital executives and managers know that the plan must use only the hospital's services.

Underestimating the Value of Plan Operations

A commonly heard reason for health systems to have their own health plan is a desire to cut out the middleman. Even hearing that phrase should lead an executive to sound Red Alert. Common sense should make it clear that if it were really that easy to successfully run a health plan, and at a lower cost too, then *somebody*

would have done it.* But pretty much every new venture that claims to have figured out a better way to do it eventually flames out or else converts to more conventional views of health plan operations.

Health plans do things for reasons, even if that is not easy to understand from the outside. Like in any industry, payers do not want to waste time, effort, and money performing meaningless tasks that drive up their costs and irritate members and providers. But if those things do not get done, regulatory and financial trouble follows and sometimes that trouble is fatal. To be clear, a hospital cannot cut out the middleman; it can only try to replace the middleman, and it must be a better, or at least an equal middleman than its competitors.

Economies of Scale

Closely tied to the middleman administrative functions are economies of scale. Even if a hospital-owned plan does things right, it still faces a problem of economies of scale, particularly in IT. Standards continually change, and it takes a lot of investment to keep up. Automation can help to control costs, but it takes time to transition to that and have it work right; even then the savings will be less than those achieved by a highly automated competitor with 20 times the number of members and offshore operations for high-volume transactions.

Bringing in executives and managers with substantial successful experience in the payer industry can help deal with this, but only if they have proper system, IT, and managerial support. Outsourcing some of this to a larger and more experienced TPA can also help, but the cost of that must include the TPA's profit margin.

Financial Management of Risk

This topic has been addressed already but is included here to emphasize it once again. Hospital financial managers usually have a good grasp of normal accounting principles and methods, but not of those related to the management of financial risk. A factor that makes this issue particularly challenging for hospitals and health systems is that they are often cash poor because they must meet payroll, stock medical inventory, and so forth but do not receive non-risk-based revenue until well after services have been provided and costs incurred. It can be a painful exercise in discipline for a hospital financial executive to put capital into an off-limits reserve for claims and IBNR, and statutory capital.

Adverse Selection

This topic has already been discussed but is addressed here again because it is such a significant challenge for hospital-owned health plans. As you now know, adverse selection simply means that people who sign up for the hospital-owned health plan may be doing so because they are sick and have had services from the hospital or its physicians already. People with medical conditions will be more concerned with the actual medical care than the coverage or the premium cost.

Hospital-owned health plans make this substantially worse when they think of plan enrollees as patients, not members. This is natural because those working in hospitals, and healthcare providers in particular, are in the business of caring for patients. But it undercuts the obvious need that any plan needs more members than patients in order to fund its medical costs. Focusing, even subconsciously on patients and on those individuals who they frequently see as patients, is a way to ensure that a hospital-owned health plan will experience adverse selection.

As noted in the introduction to this final section, all of these challenges can be overcome or avoided, as seen in the many examples of

* By "somebody" the author includes himself.

successful and long-standing hospital-owned health plans *and* successful overall health systems. But overcoming or avoiding these challenges does not happen by itself. It requires some fundamental reorienting of the system, skill, perseverance, and sufficient capital.

Conclusion

Administrative activities make up most of what a payer does from day to day, even though it represents only 15%–20% of the premium dollars. Typical administrative functions include enrolling members; checking and verifying eligibility for coverage; billing groups and individuals for premiums or administrative fees; managing authorizations and other aspects of medical management; managing benefits and claims; helping members resolve problems; managing the complaints, appeals, and grievances processes; managing operational finances and maintaining adequate reserves; filing a variety of state and federal reports; and continually developing and managing the IT systems necessary to perform all of these tasks and more.

CHAPTER 7

Medicare Advantage and Medicaid Managed Care

LEARNING OBJECTIVES

- Explain the Medicare benefit structure.
- Understand the basic elements and requirements for private Medicare Advantage plans.
- Understand the basic elements and requirements for private managed Medicaid plans.
- Explain the difference between plans serving the typical Medicare and/or Medicaid population and those serving beneficiaries who have special needs and/or who are dual eligibles.
- Understand key legal and regulatory issues in the government entitlement programs that affect private managed care plans.
- Understand the unique key aspects of how Medicare pays Medicare Advantage plans.
- Explain at a high level the basics of the Medicare Quality Bonus Payment Program, also called Medicare Stars or simply as Stars.

Introduction

As discussed in Chapter 1, Medicare and Medicaid came into existence through laws passed in 1965 and represent two of the most significant healthcare marketplace reforms ever passed in the United States. As discussed in Chapter 2, both are entitlement programs, meaning individuals who meet each program's requirements are entitled to obtain coverage. In some cases, individuals may be eligible for both Medicare and Medicaid, in which case they are referred to as dual eligibles or sometimes as "duals." Medicare and Medicaid are subject to many federal laws and regulations, a few of which are noted in the chapter as appropriate.

Most payers offer private Medicare Advantage (MA) products and/or Medicaid managed care plans, and some companies focus solely on one or the other. There are some shared elements in how payers sell and manage their commercial (nonentitlement) health plans and how they do so for MA and

Medicaid, but there are substantial differences as well.

Finally, the content and descriptions in this chapter were current at the time of publication, but there is no guarantee that it will all be completely accurate when you are reading this. Both Medicare and Medicaid are dynamic programs, meaning that except for the basic entitlement program benefits, they change from year to year. This is particularly true for how private plans are paid, but also applies to multiple other requirements too because they were designed to change. Furthermore, as we saw in the sections of Chapter 2 on benefits and on access and in the section of Chapter 6 about insurance exchanges and related topics, political changes have resulted in significant and ongoing changes in existing policies and regulations. Medicare and Medicaid are not immune to this either. The reader is therefore encouraged to seek up-to-date sources of information as necessary.

Medicare

Medicare provides healthcare benefits for the elderly, for persons with end-stage renal disease (ESRD; also known as kidney failure), and for some disabled persons. The Medicare program is administered by the federal Centers for Medicare & Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. The other federal agency involved with Medicare is the Social Security Administration, which manages eligibility and enrollment for both Social Security and Medicare benefits.

CMS administers the program from a policy and regulatory standpoint, but day-to-day operational administration of the traditional Fee-for-Service (FFS) Medicare program, such as handling claims and provider payment, is done by private companies called intermediaries that are under contract with CMS. Payment in the traditional program generally uses nonrisk methods, such as the resource-based relative value scale and Medicare Severity-Adjusted Diagnosis Related Groups, though CMS has also been piloting various value-based payment methods that contain some elements of risk; all of which are described in Chapter 4. But the traditional FFS Medicare program is not the only option for most beneficiaries, and that is the focus of the first section of the chapter.

Medicare Benefits: The Sum of the Parts

Medicare benefits coverage is divided up into Parts A through D, as illustrated in **TABLE 7.1**. Parts A, B, and D are associated with specific benefits, but Part C is associated only with enabling private health plan options for Medicare. Seniors must enroll in Medicare when they are first eligible to receive any benefits or face financial penalties, and cannot enroll in any Medicare-related private options until they have enrolled first in Medicare.

Parts A and B

Mirroring the earliest commercial health insurance and Blue Cross and Blue Shield plans, the traditional Medicare benefits consist of Part A (inpatient hospitalization coverage) and Part B (benefits for major medical coverage). Medicare coverage through Parts A and B has existed since the program began. Both Part A and Part B benefits have deductibles and coinsurance.

Part A is mandatory for all individuals eligible for Medicare coverage. Part A covers inpatient hospital care for 90 days per illness, plus 60 lifetime reserve days; 100 days per illness for posthospital skilled nursing facility care; hospice; and some home health care. Beneficiaries do not pay premiums (unless they failed to enroll when first eligible) but do have cost sharing through deductibles and coinsurance. There is no annual or lifetime

TABLE 7.1 Medicare Parts A Through D

Part A	Part B
■ Inpatient acute hospital care and up to 100 days of skilled nursing facility care ■ Hospice care ■ Limited postdischarge home health services ■ Funded by payroll taxes and general revenues	■ Physician services and outpatient hospital care ■ Preventive care (added under the Affordable Care Act [ACA]), mental health care, and home health services ■ Diagnostic procedures and DME ■ Funded by income-adjusted premiums paid to the government and from general revenues
Part C	**Part D**
■ Private MA plans members may elect to receive Medicare-covered benefits ■ MA plans at full risk for Parts A and B, and often Part D benefits, plus additional benefits if approved by CMS ■ Medicare pays MA plans from Parts A and B, and plans may charge a premium as approved by CMS	■ Voluntary[1] outpatient prescription drugs benefits ■ Provided entirely through private plans that contract with Medicare ■ Two types of plans: stand-alone Part D Prescription Drug Plans and MA Prescription Drug Plans ■ Funded by income-adjusted premiums paid to the government and used to subsidize cost, and plans may charge a premium as approved by CMS

[1] Dual eligibles are automatically enrolled in Part D for coverage of prescription drugs.

limit on the amount of cost sharing. Part A is at least partially funded through payroll deductions made over at least 30 quarters during people's working years, though payroll deductions only cover about one-third of the actual costs. Those who are eligible for Part A but did not have enough payroll deductions may still obtain it by paying a premium.

Part B is voluntary for individuals who must also have Part A, and it covers physician services, outpatient hospital care, preventive care, mental health care, most home health services, diagnostic procedures, and durable medical equipment (DME). Part B enrollees must pay a quarterly premium that is adjusted for annual income, and payments may either be deducted from Social Security payments or paid directly by the beneficiary.

Individuals are initially eligible to enroll in Parts A and B over 7-month period that starts 3 months before turning 65, plus their birthday month, plus 3 months after that. Part B now provides benefits for many preventive services. Neither Part A nor Part B provides benefits for coverage of prescription drugs. For many years, the only way seniors could obtain coverage for costs that Medicare did not cover was through a Medicare Supplemental Insurance policy, also called "Med Sup" or sometimes "MediGap." Med Sup is not addressed in this chapter.

Part C

In the mid-1980s, another option became available when a pilot program was authorized that allowed private plans that met various criteria, such as federally qualified health maintenance organizations (HMOs; see Chapters 1 and 2) to market and sell private Medicare plans in place of traditional FFS Medicare. The private plans could cover more than what

traditional Medicare covered, but not less. That created a new option for seniors in some markets, because many private HMO plans included coverage for prescription drugs and preventive medical services, although they were not required to do so. At that time however, it was only a pilot program and was not associated with a specific Medicare Part.

In 1997, Medicare Part C was passed as part of the Balanced Budget Act (BBA; see Chapter 1). Part C is not a benefit, but rather a provision that made permanent the option for beneficiaries to voluntarily receive their Medicare benefits through an approved private plan if one was available to them. When it was originally implemented, the Part C option was called Medicare+Choice.

The BBA also expanded the different types of private plans that could be approved under Part C, including preferred provider organizations (PPOs), point-of-service (POS) plans, a new type of Medicare plan called private fee-for-service (PFFS), and a demonstration program for medical savings accounts (MSAs). The BBA also created an ill-fated Medicare pilot program for provider-sponsored organizations (PSOs) that had lobbied to take full risk by contracting directly with Medicare and compete with Medicare+Choice plans; most PSOs failed—some spectacularly—and the pilot program ended.

To be eligible to join a Part C plan, beneficiaries must have Medicare Parts A and B. Beneficiaries cannot have both a Part C plan and a Med Sup policy. These requirements remain in place today, in addition to other requirements, some of which are briefly described later.

Part D

The Medicare Prescription Drug Improvement and Modernization Act, better known as the Medicare Modernization Act (MMA), was passed in 2003. This act created a new benefit, Medicare Part D, which added an optional (for most beneficiaries) drug coverage benefit for all Medicare beneficiaries. The MMA also changed the name of the Part C Medicare+Choice program to Medicare Advantage. More importantly, it changed how MA plans are classified, how they are paid, and how performance is measured, among other things. Part D is described further in the next part of the section.

The Part D Drug Benefit and Prescription Drug Plans

The drug coverage benefit created under the MMA comes entirely through private entities—either stand-alone prescription drug plans (PDPs) or Medicare Advantage Prescription Drug plans (MA-PDs, also sometimes called MA-PDPs) in which the Part D drug benefits plan is combined with the Part C medical benefits plan. PDPs (and MA-PDs) must meet access standards to ensure that beneficiaries have convenient access to pharmacies. The Part D premium cost is primarily paid for by federal subsidies, with a portion being paid by beneficiaries through premiums as well as cost sharing. The private PDPs and MA-PDs are at risk for the benefit cost up until an individual's costs exceed an upper threshold.

Eligibility for Part D

Newly eligible Medicare beneficiaries may enroll in Part D as soon as they become eligible for Medicare, but only if they also first enroll in Medicare Parts A and B. Because Part D comes entirely through private PDPs or MA-PD plans, they must also enroll in one of those to receive the Part D benefit. The initial enrollment period for Medicare coverage as well as for Part D lasts 7 months. It begins 3 months before the month an individual's 65th birthday, includes the month of their birthday, and extends for 3 months after that.

After the initial enrollment period has ended, beneficiaries can only enroll in Part D during the annual open enrollment period in the fall of each year, unless they qualify for a

Special Enrollment Period (SEP). SEPs are like the qualifying events described in Chapter 6, but specific to Medicare Parts C and D. A few examples (there are many) of events that qualify a beneficiary for an SEP include the following:

- Moving out of the PDP or MA-PD service area
- Losing employer-based coverage or Medicaid
- A new ability to be covered through some other means that has a drug benefit
- The PDP or MA-PD plan changes its contract with CMS

If a beneficiary chose not to enroll for Part D when it was first available to them, they must pay higher premiums should they decide later that they want Part D during a subsequent open enrollment period. However, if they had creditable coverage, meaning other drug benefit coverage at least as good as Part D, up until that time they will not have to pay higher premiums.

Part D is voluntary for regular Medicare beneficiaries, but dual eligibles are automatically enrolled in the program as a replacement for Medicaid drug coverage. Because dual eligible individuals typically have low incomes, they also qualify for financial assistance from Medicare and from states to cover premiums and most cost sharing.

Part D Benefits

The Standard Part D benefit is complicated. It has varying amount of member cost sharing, all of which add up over the course of a benefit year to what CMS calls True (or Total) Out-of-Pocket (TrOOP) costs.* The Part D benefit has a deductible, after which the initial coverage period begins, which includes a 25% coinsurance requirement. After reaching a defined TrOOP cost level, coverage enters a gap that is not really a gap, but a period in which the drug benefit is paid through a combination of member cost sharing, discounts by drug manufacturers, and the PDP or MA-PD plan. When the TrOOP cost exceeds another (higher) defined amount, coinsurance drops to 5%. The dollar amounts for the deductible, for when the first level of coverage begins, when the coverage gap begins, and when the maximum TrOOP cost has been reached are determined each year by the government. The Standard Part D benefit as of 2019, including how risk is distributed between PDPs/MA-PDs, drug manufacturers, and CMS, is illustrated in **FIGURE 7.1**.

The initial Part D benefit created under the MMA was created like a consumer-directed health plan (see Chapter 2), which includes a coverage gap—sometimes called a "doughnut hole"—when the enrollee had no coverage at all until TrOOP costs exceeded the catastrophic cap when coverage would resume with 5% coinsurance. But even then, many PDPs and MA-PD plans provided some coverage of generics during the gap although they were not required to.

The ACA addressed the coverage gap by slowly increasing levels of coverage during the gap beginning in 2011, mostly by requiring participating drug manufacturers to provide discounts (the amounts differed for generic vs. brand name).† The gap was originally scheduled to disappear in 2020, but in 2018 Congress moved that up to 2019, after which coverage with 25% coinsurance applies between meeting the deductible up until the catastrophic cost cap is exceeded, when coinsurance drops to 5%.

* TrOOP is a term used by the federal government, not because CMS thinks that there is such a thing as false out-of-pocket costs, but to differentiate it from Maximum Out-of-Pocket (MOOP) costs that apply to Part A and Part B benefits in MA plans (but not traditional FFS Medicare). Other than for their MA plans, MA-PD plans, or PDPs, payers typically do not use the acronyms TrOOP or MOOP.

† The value of those discounts counts towards a member's TrOOP.

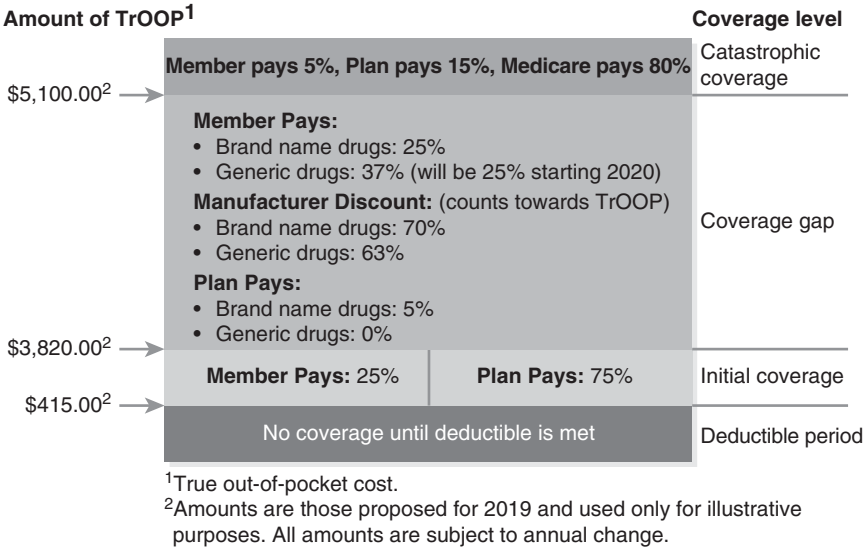

FIGURE 7.1 2019 Standard Medicare Part D Drug Benefit

Modified from CMS description of 2018 Part D benefit, at www.medicare.gov

PDPs and MA-PDs may provide benefits richer than the Standard Part D benefit, but not less. Bear in mind that most PDPs and MA-PDs provide somewhat richer benefits than the Standard Part D benefit; for example, requiring only a fixed copay for generic drugs during the coverage gap instead of the member having to pay the entire coinsurance amount. There is a low-income subsidy of premiums and cost sharing for those who qualify. There is no annual or lifetime limit on cost sharing. Finally, like so many other aspects of health care subject to policy changes and political forces, Part D benefits have changed every year since the MMA was passed.

Formularies and Drug Utilization Review

Like any type of managed care plan, PDPs and MA-PD plans must manage the overall cost of the benefits provided. Many of the same approaches used for managing the drug benefit in commercial plans are used by PDPs and MA-PD plans and were described in Chapter 5. These include using of a formulary; drug utilization review including prior authorizations and step therapy; quantity limitations; encouraging the use of generics; and the like. But there are differences as well.

Unlike how formularies are developed and used for commercial plans, formularies for Part D must comply with many additional requirements. For example, PDP and MA-PD formularies must include drug categories and classes that cover all disease states. Each category or class must include at least two drugs unless only one drug is available for a specific category or class; or two drugs are available, but one drug is clinically superior to the other. Like commercial formularies, Part D formularies may contain medical necessity criteria for coverage.

Formularies must be preapproved by CMS, so they are submitted to CMS in April of each year before they would be used. CMS reviews them to assure that they are adequate, that they include a range of drugs in a broad distribution of therapeutic categories and

classes, that they are not designed to discourage enrollment by individuals with significant illnesses, and more.*

Medication Therapy Management Programs

PDPs and MA-PDPs are required to have a medication therapy management (MTM) program, approved by CMS, that seeks improved outcomes, that focuses on beneficiaries who have multiple chronic diseases and high drug costs, and that looks to reduce the risk of adverse events related to medications. For example, MTM programs target chronic conditions, such as hypertension, heart failure, and diabetes. MTM programs must also focus on beneficiaries who incur annual drug costs of approximately $4000 or more, a figure than changes each year. MTM programs include processes, such as a comprehensive medication review, ongoing monitoring, and beneficiary or prescriber interventions if necessary. MTM programs are also built into the requirements for accountable care organizations discussed in Chapters 1 and 3.

Part C Medicare Advantage

As noted earlier, Part C was created in 1997 under the BBA and underwent some substantial changes under the MMA. Part C plans must cover at least all Part A and Part B benefits, plus at least one in each service area must include Part D benefits as an MA-PD plan. The MMA also expanded existing federal preemption of state law over MA plans for many operational (but not financial) aspects, a topic that is addressed later in the chapter.

Eligibility for Coverage by a Medicare Advantage Plan

Like Part D, the initial enrollment eligibility period for coverage through an MA plan lasts 7 months. It begins 3 months before the month an individual's 65th birthday, includes the month of their birthday, and extends for 3 months after that. Beneficiaries must enroll in Medicare Parts A and B before they can enroll in an MA plan. Newly eligible beneficiaries who do not choose an MA plan are deemed to have chosen the traditional FFS Medicare option.

After the initial eligibility period, beneficiaries may enroll in an MA plan during an annual fall open enrollment period. Unlike Part D, individuals who did not sign up for an MA plan when they were first eligible do not face a financial penalty if they enroll in a future open enrollment period. A beneficiary may also be eligible to enroll in a Part C plan if they qualify for an SEP as described earlier for Part D. Dual eligibles may not have the option of enrolling in any available MA plan, however, but instead may be enrolled in a different type of managed care plan by the state.

The only Medicare beneficiaries who are not entitled to enroll (and to whom an MA plan must refuse enrollment under the law) are those who have ESRD, whether aged, disabled, or entitled to Medicare solely because of their disease. However, enrollees who acquire ESRD after enrollment in the plan may not be disenrolled because they have ESRD, and individuals who were enrolled as non-Medicare members of a plan who have ESRD may be retained as Medicare enrollees upon becoming eligible for Medicare. An exception to this rule is that Special Needs Plans (SNPs†) may be offered to individuals with ESRD who would not otherwise be entitled to enroll in an MA plan.

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* Much more. The chapter in the CMS Part D prescription drug benefit manual addressing formulary requirements alone is 83 pages long, and it is only the third largest chapter focused on Part D. Even then, it has cross-references to other sources to access additional details of formulary requirements.

† The industry verbal slang term for SNPs is "Snips." It is only verbal shorthand, not an insult, and it contains no hidden meaning.

Types of MA Plans

The MMA defines four categories of MA plans that private payers can be approved to offer to Medicare beneficiaries:

- Coordinated care plans (CCPs), which are required to offer at least one plan with Part D benefits throughout their service area but are free to also offer plans without Part D as well. CCPs are the most common type of MA plan.
- PFFS plans, which are allowed, but not required, to include Part D coverage.
- MSA plans, which are not allowed to include Part D at all.
- Group retiree plans that are MA plans restricted to only employer or organized labor groups and that include coverage for health care in their defined benefits plans for retirees.

CMS refers to these plans broadly as Medicare Advantage Organizations (MAOs), but common usage simply calls them MA plans. CMS must approve any plan offered before it may enroll members. Other than retiree plans, MA plans are also licensed and regulated by the states as risk-bearing insurers or HMOs.

At the time of this text's publication, approximately one-third of all Medicare beneficiaries were enrolled in an MA plan, and that number continues to grow. Two-thirds of those who are in an MA plan are in MA HMOs.

Coordinated Care Plans

CCPs refer to the different types of health plans that use a network of providers to provide and manage the benefits package approved by CMS. CCPs include HMOs, POS plans, and PPOs, as well as the more focused SNPs. Because they are required to be state-licensed risk-bearing companies or organizations, they are the same as what were described in Chapter 2 but are subject to additional Medicare-related requirements.

CCPs, including PPOs, may enroll beneficiaries only within a defined service area (see Chapter 2) approved by CMS. CMS must approve the provider network to assure that the enrolled Medicare beneficiaries will have sufficient access to covered services, and plans must routinely monitor and report on network adequacy. CCPs may use financial incentives and utilization management (UM) to control the use and cost of services and must meet quality requirements.

Medicare HMOs, including POS plans based on HMOs, are the oldest coordinated care plan type and have the highest enrollment among all types of MA plans. Unlike many purely commercial PPOs, MA-PPOs must meet the MA quality requirements, albeit only for services provided on an in-network basis, and they must meet network adequacy service area requirements that may differ from state requirements.

The MMA distinguishes between two types of PPOs: local PPOs and regional PPOs (RPPOs). Local PPOs have the flexibility to choose the service area where they will operate (e.g., one or multiple counties). RPPOs were added to Medicare by the MMA to provide increased access to private plans, particularly in rural counties. RPPOs must serve all counties in one or more of 26 statewide or multiple-state regions designated by CMS. To encourage the growth of RPPOs, CMS did not allow any new local plans to start up for 2 years in the designated regions, but that restriction was lifted in 2008.

PPOs must establish a MOOP limit for in-network services, and all CCPs must establish a catastrophic or maximum limit on total out-of-pocket spending. CMS refers to the maximum total out-of-pocket cost as the MOOP* cost. Once the MOOP cost is met, there is no more cost sharing for the rest of the year.

* MOOP cost applies to the Part A and Part B benefits through an MA plan. The acronym MOOP differentiates it from the TrOOP cost that applies to the Part D benefit. TrOOP and MOOP are separate and one does not affect the other.

Special Needs Plans

SNPs are CCPs, usually HMOs, that focus on unique aspects and challenges of medical management and eligibility that are reflected in the three types of SNPs designated by CMS:

- D-SNPs: Dual-eligible SNPs for dual eligibles
- I-SNPs: Institutional SNPs for beneficiaries who are institutionalized in a skilled or intermediate nursing facility, or in an assisted living facility
- C-SNPs: Chronic care SNPs for beneficiaries with one or more severe or disabling chronic conditions

The ACA created a requirement that all SNPs meet a scored set of standards in an SNP Model of Care (MOC), which is based on standards created by the National Committee for Quality Assurance (NCQA), a major accreditation organization for healthcare plans (see Chapter 5). MOCs are scored, and SNPs must achieve a minimum score of 70% to pass, and at least 75% to be able to contract with CMS for more than 1 year.

Private Fee-for-Service Plans

PFFS plans were authorized in 1997 and are a model unique to Medicare. Enrollees are permitted to self-refer to any Medicare provider willing to accept the individual as a patient consistent with the rules of the plan regarding coverage. The PFFS plans pay providers using the same methods and amounts that Medicare uses, though they may pay more if they choose; they do not place the provider at financial risk; and they do not vary its payment rates based on utilization. A PFFS plan, however, is permitted to vary its payment rates based on the provider's specialty, location, or other factors not related to utilization.

PFFS plans and enrollment grew very rapidly beginning in 2006 when MMA payment rates, which were relatively high, went into effect. Because there was no cost associated with establishing provider networks, there was little barrier to entry. Consequently, by 2008, PFFS plans were available to almost all Medicare beneficiaries in the United States. In 2011, PFFS plans were required to establish networks and meet quality requirements, and the amount the PFFS plans were paid was reduced, leading the majority of PFFS plans to drop out of the market. PFFS plans still exist but are negligible in terms of the number of plans and total enrollment.

Medical Savings Account Plans

MSAs authorized under the BBA were intended as a demonstration only and, in fact, few were ever sold. The MMA continued to authorize MSAs, however, including a new Medicare MSA demonstration program. An MSA plan is similar to a commercial MSA or a consumer-directed health plan (CDHP; see Chapter 2). Like a CDHP or a commercial MSA, Medicare MSA plans have a special type of Part C high-deductible plan coupled with an MSA.

MSAs have not had much success in the Medicare market, or for that matter, the commercial market either. The MSA plans are often confusing to beneficiaries, and the plan design does not allow beneficiaries to personally contribute to their tax-free accounts. Furthermore, Medicare MSA plans are not allowed to offer Part D drug benefits, which must be purchased separately. Medicare MSAs are not addressed or otherwise included in the chapter beyond this point.

Group Retiree Plans

CMS has historically offered MA plans wide latitude to negotiate with employers and unions for retiree coverage under MA. The MMA went even further by including a very broad waiver provision to encourage employer- or union-sponsored plans to offer retiree coverage through MA plans and PDPs, and it added a new option whereby employers or unions could directly contract with CMS as MA, PDP,

or MA-PD plans. As part of that revision, retiree MA plans do not need to meet all of the requirements that commercial MA plans do, such as minimum enrollment levels or service area restrictions, and they follow the employer's or union's eligibility rules for enrolling retirees.

Sales and Marketing

Except for group retiree MA plans, MA plans market and sell their products to individual Medicare beneficiaries, and a beneficiary's decision to join an MA plan is a personal one. In other words, all MA coverage is individual coverage, not family or group.

Whereas marketing and sales of insured products in the commercial markets are regulated only by the states, marketing and sales of MA plans must not only meet state requirements, but also federal requirements. These requirements are extensive and complex in what must be done, what is allowed, and what is prohibited. A very few examples of what they must do include things, such as:

- The MA plan must market throughout the entire service area in a nondiscriminatory manner.
- All marketing materials, including membership and enrollment materials, must use approved model language and must be approved by CMS before use, although there is a time limit on CMS's review process.
- Prospective enrollees must be given sufficient descriptive materials to allow them to make an informed decision regarding enrollment.
- Prospective enrollees must be given a summary of benefits form that uses standard definitions of benefits and a standardized format, like the one described in Chapter 6.

Many sales and marketing activities are explicitly prohibited, and an MA plan that engages in these activities may be subject to fines, suspension of its ability to sell to or enroll new members, or even the loss of its contract with CMS as well as other sanctions. These strict prohibitions were established because of abusive marketing and sales practices in the past. The list of prohibited marketing and sales activities is quite extensive and longer than the list of required actions. A very few examples include:

- Using a purchased list of e-mail addresses or other types of lists to contact nonmembers
- Door-to-door solicitation or leaflet distribution
- Referring to a plan as "the best" or anything that sounds like that
- Comparing one MA plan to another, unless using only CMS's star ratings (described later in the section)
- Discriminatory marketing (e.g., avoiding low-income areas or people with medical problems)
- Misleading marketing or misrepresentation in the marketplace
- Requesting any beneficiary identification numbers, such as a Social Security number or personal contact information
- Providing gifts worth more than $15 to attend a meeting
- Offering monetary incentives as an inducement to enroll
- Completing any portion of the enrollment application for a prospective enrollee
- Any sales by any means by a person who is not licensed by the state, and/or not trained and certified by CMS to sell MA plans

CMS defines limits on the amount of commissions that brokers may be paid for enrolling members into an MA plan. The limits can vary by location and are periodically updated. Commissions are higher for an initial enrollment, but not for "churning" (i.e., a broker or agent cannot have people change plans just to get a higher commission).

CMS requires any brokers, agents, or plan sales personnel to obtain MA-specific training from an organization approved by CMS. Brokers and agents must also be licensed by the state. CMS also established requirements for websites and call centers that facilitate sales, marketing, and/or enrollment.

Open Enrollment

All MA plans, unless they are at capacity and unable to accept new members, hold an annual open enrollment, called the annual election period, that takes place from October 15 through December 7 of each year, though CMS can change that. During open enrollment, beneficiaries may receive information about all the coverage options available to them, including various MA plans or PDPs, or Med Sup policies. During open enrollment, beneficiaries may change from one MA plan to another, elect new coverage, or switch from MA to traditional Medicare and vice versa; changes are effective on January 1 of the upcoming year.

The annual open enrollment period is followed by a disenrollment period that runs from January 1 to February 14, during which a beneficiary can disenroll from an MA plan and return to traditional Medicare. Once the disenrollment period closes, beneficiaries are locked in to whatever option they chose for the remainder of the year, with some exceptions. Note that this election period does not allow for enrollment in a new MA plan, only for opting out of MA for the year, though they have the option to join a PDP to add drug coverage.

CMS requires MA plans to accept enrollment requests in various formats. Examples include:

- Face-to-face meetings between beneficiaries and plan enrollment personnel, though recall that no plan personnel can fill out an enrollment form for a beneficiary
- Telephonic enrollment originated by the beneficiary and with no agent or representative present during the call
- Enrollment forms sent through the mail
- Enrollment forms sent by facsimile
- Enrollment through the MA plan's own secure Internet website
- Other methods defined and/or allowed by CMS

Once the member is enrolled, the MA plan must provide an evidence of coverage (EOC) that is like the EOC used for commercial plans (see Chapter 6). The EOC includes information on benefits and exclusions; the number, mix, and distribution of plan providers; out-of-network and out-of-area coverage; emergency coverage (i.e., how it is defined and how to gain access to emergency care, including use of 911 services); prior authorization or other review requirements; grievances and appeals; and a description of the plan's quality assurance program. On request, the organization must provide information on utilization control practices, the number and disposition of appeals and grievances, and a summary description of physician compensation. Finally, the EOC must include information specific to Medicare, such as special protections and access to CMS.

Payment of Medicare Advantage Plans

Payment of MA plans is convoluted and unlike any type of plan payment method used in the commercial market. It also changed radically—for good reason—with the passage of the MMA. Prior to the MMA, Medicare+Choice plans were paid based on 95% of the Average Area Per Capita Cost (AAPCC), computed by using average local costs in the traditional Medicare program for each of 122 different rate cells factored for age, sex, dual eligibility, institutional status, and whether a person has both Parts A and B. This resulted in very high payments in high-cost metro areas and very low payments elsewhere, as well as a windfall profit for Medicare+Choice plans that had favorable selection.* Under the BBA, the total amount paid to plans was slashed, causing Medicare HMOs in low-cost markets

* A small but significant number of plans drove favorable selection through marketing and sales practices that now appear on the list of prohibited activities seen earlier in the chapter. This was especially so in some very costly and dynamic markets, such as South Florida.

to leave, but putting only a small dent in the profits of those in high-cost areas.

Under the MMA, payment to MA plans changed significantly to the system that is described next. The ACA did not change the basic program, but it reduced payment rate increases to MA plans overall, and readjusted payment averages into four categories so that plans in high-cost areas received lower payment percentage increases (or even decreases), while plans in low-cost areas received higher payment increases. With that background, what follows from this point forward is an overview of the method CMS uses for calculating MA plan payment.

MA plans are paid through on an annual process called a bid that determines how much they will be paid by CMS, how much in premiums (if any) an enrollee must pay, and how much member cost sharing will be applied to Part A and Part B covered benefits. Bids for Part D benefits are calculated and submitted separately by MA-PD plans. Most MA plans also typically offer more than one type of product in the same market, and each of those products goes through its own bid process. The MA plans perform many of the calculations as part of their bid submissions, but CMS is responsible for final determinations.

MA plan payment has five interrelated major components, the first four of which affect payment from CMS:

1. Benchmark or Base payment
2. Risk adjustments based on individualized Hierarchical Condition Categories (HCCs), also known as risk scores
3. The Quality Bonus Payment (QBP) program, also known as Star Ratings or simply Stars
4. A type of bonus called a Rebate
5. Premiums charged to enrollees

The specifics of these five components are complicated and can be described here only in very broad and overly simplified terms. Even these five components do not cover everything, but the many other components that are—or may be—involved are way beyond the scope of the book and this already complicated section. The five main components are described next.

Benchmark or Base Payment of Medicare Advantage Plans

The benchmark is the base bidding target for an average Medicare beneficiary. The benchmark is first determined each year by looking at local costs in the traditional Medicare program for the standard Part A and Part B benefits and cost sharing. This is the minimum level of benefits, meaning no MA plan can provide fewer benefits or more cost sharing,* but it may provide more benefits and/or less cost sharing if approved to do so by CMS.

It is not quite that straightforward because CMS adjusts the benchmark based on county-specific MA payment rates used prior to 2006, not the current year. CMS also adjusts the benchmark for cost trends and location, as well as "code creep," meaning the increasing use of diagnostic codes that adjust payment upward. In this and many other ways, the benchmark is very different from the old AAPCC.

CMS compares an MA plan's basic bid to the benchmark. The bid is the plan's prediction of its costs for the standard benefit in the upcoming year, including administrative costs and profit, though as of 2014 the ACA requires MA plans to maintain a medical loss ratio (MLR) of at least 85%, which mirrors the ACA's MLR limitations for insured large groups in the commercial market (see Chapter 6). If an MA plan has adequate claims history data, it uses those data, at least in part, to predict or estimate its future costs. If it has no history, then it must estimate costs from CMS data and/or estimates provided by actuaries.

But the process is far from over. Before the comparison of the bid to the benchmark is

* Coverage of hospice is an exception and is not included in CMS's benchmark calculation.

made, there are more factors and adjustments that CMS applies to both benchmark and bid on a plan-specific basis. The most important of these factors are the plan's HCC risk scores and its Star ratings. Both are described next.

Hierarchical Condition Categories

Another substantial difference between the benchmark calculation and the old AAPCC is the use of HCC risk scores. There are two primary reasons this was included in the changes to MA plan payment. First was to eliminate any incentive for MA plans to encourage favorable selection, because the amount of payment would reflect the expected costs for a plan's actual risk pool. Second was to make plan payment fairer.

HCC risk scores account for the specific characteristics of an MA plan's enrollees. HCC scores include factors for the age, gender, place of residence, and prior health condition of each individual Medicare beneficiary enrolled in each MA plan. These data are used to project the expected relative risk for each enrollee, meaning the likelihood of each MA plan enrollee having higher or lower than average medical costs compared to the standard projected benchmark. The individual risk scores are combined into an aggregate risk score that is then used to adjust the standard benchmark used for the bid comparison of the MA plan.*

HCC risk scores are based on claims codes for diagnoses and procedures, as well as some other factors, for both the traditional Medicare program (which goes into the standard benchmark calculation) and for each MA plan. To address problems of data lag, MA plans also submit data on an ongoing basis, and CMS periodically conducts audits to test the validity of submitted claims and other data.

CMS does not revise risk-adjusted payments to MA plans until July of each plan year, initially using prior scores. In July, CMS retroactively adjusts payments for prior periods on a member-specific basis. MA plans may accrue (i.e., book) the expected HCC adjustments as revenue even though they do not get the cash for many months.

Quality Bonus Payment Program

The QBP was put in place as a demonstration under the MMA and made permanent under the ACA. The QBP is also known as the Medicare Stars or Star Rating program because a plan's rating is summarized by the number of stars and half-stars it receives, with five stars being the highest rating.† The QBP program is designed to be modified each year, so its description here reflects only what was in place at the time of publication. Up-to-date information on any updates and changes to the QBP program can be found on CMS.gov.

Like we saw for adjustments based on HCC risk scores, the bonus or rebate is calculated by adjusting the benchmark. Only plans that receive four or more stars are eligible to receive any bonus.‡ The amount of savings from a bid that is lower than the benchmark is also affected, such that plans with higher star ratings may keep a higher percentage of the savings as a bonus. But a QBP bonus is not something an MA plan can simply take as income. It must be used to fund additional benefits for MA enrollees, reduce their amount of cost sharing, and/or reduce premiums charge to enrollees. MA plans with five stars are also allowed to market and sell to beneficiaries all year long, not just during annual open enrollment periods, which is of great value to an MA plan.

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* As a practical matter, it is easier to see this process as adjusting the bid, particularly because MA plans keep track of their overall aggregate HCC risk score for each MA product. But as a technical matter, it is used to adjust the comparison.

† NB: While the QBP is generally referred to as Stars, be aware that at the time of publication, CMS has been using a version of the QBP for hospitals and for commercial plans offering products through health exchanges, so the terms Stars or Star Ratings are no longer only used for MA.

‡ A bonus is different than a rebate, which will be addressed later in the section.

Categories of Star Ratings change from time to time. In 2018, MA plan Star Ratings fell into the five categories shown in **TABLE 7.2**, while Star Ratings for PDPs and MA-PDs fell into the four categories shown in **TABLE 7.3**. Star Ratings for MA-PD plans include both sets of categories.

Data for the Star Ratings are also modified from time to time. In 2018, the following six data sources were used:*

1. Data Collected by CMS Contractors, such as companies that perform audits and assessments on behalf of CMS
2. The CMS Complaint Tracking Module
3. Medicare Part D Data Files (PDPs and MA-PDs only)
4. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
5. The Healthcare Effectiveness Data and Information Set (HEDIS®)
6. The Health Outcomes Survey (HOS)

As important as the bonus rebate is for plans with four or more stars, the star rating program also contains penalties for plans that have fewer than three stars, which are dubbed poor-performing plans by CMS. If a Medicare beneficiary or an individual who will soon become eligible for Medicare coverage uses CMS's www.Medicare.gov website to find a plan, the site only provides links to plans with three or more stars. For plans with fewer than three stars for 3 years, the website provides no

TABLE 7.2 2018 Star Ratings Categories and Weights for MA Plans Covering Parts A and B

Star Rating Category	Content of Rating Category	Relative Weight (%)
Staying healthy: screening tests and vaccines	Includes whether members got various screening tests, vaccines, and other check-ups to help them stay healthy.	21
Managing chronic (long-term) conditions	Includes how often members with certain conditions got recommended tests and treatments to help manage their condition.	35
Member experience with the health plan	Includes member ratings of the plan.	17
Member complaints and changes in the health plan's performance	Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.	17
Health plan customer service	Includes how well the plan handles member appeals.	10

Modified from https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx. Accessed on April 29, 2018.

* See Chapter 5 for descriptions of sources 4–6.

links and it advises beneficiaries such plans do not meet Medicare's standards for quality. To enroll in a poor-performing plan, an individual must contact that plan directly. CMS also can remove a poor-performing plan that has had fewer than three stars for 3 years in a row from participating in the MA program altogether.

Rebates

In the next step of the MA plan payment calculation, CMS compares each plan's bid to its benchmark that has now been adjusted for HCC risk scores and star ratings. This determines the rebate amounts for the year, if any. Plans that bid below their adjusted benchmark receive a rebate in the form of a fixed percentage of the difference between the plan's bid and its adjusted benchmark; the federal government keeps the rest. As of 2018, the fixed percentages are 50%, 65%, and 70%, depending on a plan's Star Rating (higher Star Ratings receive the higher percentage); the exact percentages can change from time to time.

The MA plan receives the rebate, but not as something it can keep. The plan must return the amount of the rebate it receives to its Medicare enrollees in the form of supplemental benefits, lower cost-sharing, and/or Part B premium subsidies. In other words, just as we saw in the QBP, the MA plan cannot pocket the money. However, it can include a small profit percentage into the cost of supplemental benefits covered by the rebate.

Premiums

If a plan's bid is higher than the adjusted benchmark, then CMS pays an amount equal to the adjusted benchmark and enrollees must pay an MA plan premium that makes up the difference. Plans that are below the benchmark are paid based on their bid, not the adjusted benchmark. Plans that bid below the adjusted benchmark do not charge a premium for the

TABLE 7.3 2018 Star Ratings Categories and Weights for PDPs and MA-PDs (Part D Only)

Star Rating Category	Content of Rating Category	Relative Weight (%)
Drug plan customer service	Includes how well the plan handles member appeals.	15
Member complaints and changes in the drug plan's performance	Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.	30
Member experience with plan's drug services	Includes member ratings of the plan.	10
Drug safety and accuracy of drug pricing	Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safe and clinically recommended for their condition.	45

Modified from https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx. Accessed on April 29, 2018.

standard benefits but can charge a premium for any extra benefits offered that were not completely offset by a rebate.

Network and Medical Management in Medicare Advantage Plans

Network and medical management in MA plans is generally the same as we saw described in Chapters 4 and 5 for commercial health plans. This includes elements, such as provider payment, network access requirements, UM, disease management (DM), case management (CM), and so forth. As we also saw in those chapters though, CMS may have Medicare-specific requirements as well, such as the metrics used to define network adequacy.

As expected, utilization by seniors is higher than what it is for commercial members, but there is wide variation in just how much higher. For example: The average inpatient length of stay is one and a half times higher, the average rate of physician visits per member per year is twice as high, and the average rate of inpatient hospital bed days per thousand is almost six times higher* (see Chapter 5 for descriptions of metrics). Seniors also have, on average, more chronic medical conditions and, including more multiple chronic conditions. For these and other reasons, UM and DM in MA plans require more resources than in commercial plans. The emphasis on certain skill sets is also higher; for example, DM usually requires increased skills in working with those with multiple chronic conditions.

Demand management and prevention are also similar to those found in commercial plans, but once again is focused on the senior population, particularly certain increased risks that seniors face. For example, hip fractures due to falls are more common in seniors and can lead to a prolonged hospital stay that is associated with a higher risk of serious complications. The most common place for a senior to fall is in the bathtub or shower, and simply providing a nonslip bath mat or even a bath chair can lower the risk of serious falls considerably for some individuals. Medication therapy is also focused in MA, as was addressed earlier.

Medicare Advantage Quality and Plan Performance Requirements

MA plans must meet several other requirements related to quality and plan performance programs in addition to what has already been addressed. Data and information for these programs are used not only by the QBP program, but for other evaluations by CMS as well. A brief description of some of these requirements follows.

Overall MA Quality Program Requirements

Quality program requirements for MA plans are at least partly similar to NCQA's accreditation requirements as described in Chapter 5. In some cases, CMS has applied its own term to a relatively standard requirement, but there are other requirements unique to MA. A few examples of some MA Quality Program Requirements include:

- Documentation of Quality Improvement Projects (QIPs) that are similar to quality management (QM) programs
- Documentation of Chronic Care Improvement Programs (CCIPs) that are similar to DM programs
- A health information system that collects, analyzes, and reports data
- Written policies and procedures documenting the MA plan's current standards

* Source of comparative data: *The Sanofi Managed Care Digest Series, Payer Digest for 2018*, based on data provided by IQVIA. Available at: http://www.managedcaredigest.com/pdf/PayerDigest.pdf (free with registration). Accessed on November 8, 2018.

of medical practice and mechanisms to detect both underutilization and overutilization of services
- Formal annual evaluations measuring the impact and effectiveness of the program, including:
  - Problems that were revealed through internal surveillance, complaints, or other mechanisms
  - Resolution of those problems

CMS requires the annual submission of the QIPs and the CCIPs in July of each year. Projects are reviewed at the contract level to identify those that show improvement or deterioration. CMS also determines an MA plan's overall compliance with these requirements and more.

MA External Review and Reporting Requirements

CCPs are subject to external review by Quality Improvement Organizations (QIOs) under contract to CMS and that also provide external review of hospital quality of care in the FFS Medicare program. QIOs review complaints by MA enrollees about the quality of care in an MA plan and process beneficiary requests for review of hospital discharge decisions. QIOs also play a significant role in member appeals of benefits denials.

Some of the additional MA plan data set reporting requirements parallel NCQA's requirements for accreditation of commercial plans. Accreditation and these data sets are briefly described in Chapter 5. One data set that is specific to Medicare is the HOS, also called the Medicare Hospital Outcomes Survey (MHOS). All data sets use measures that are specifically modified for Medicare. The required data sets are:

- The HEDIS
- The annual CAHPS survey
- The quarterly CAHPS Disenrollment Reasons Survey
- The HOS or MHOS
- Additional plan performance measures, such as call center performance, and appeal and grievance rates.

Deemed Compliance with Medicare Advantage Network, Utilization, and Quality Requirements

CMS has the authority and ability to perform its own assessments of all MA requirements, but for some requirements it will accept accreditation performed by an approved organization as well. This is called deemed compliance. This means that plans accredited by NCQA, URAC, or Accreditation Association for Ambulatory Health Care that are described in Chapter 5, are deemed to have met or exceeded MA requirements for MA program participation in the following six categories:

- Quality assessment and improvement
- Access to services
- Provider participation
- Advance directives
- Information about antidiscrimination
- Confidentiality and accuracy of enrollee records

Member Appeals

Member appeals resemble the processes discussed in Chapter 6, but there are some specific differences. In MA, the QIOs are involved in reviewing appeals of coverage denials. If the QIO upholds the denial, an MA member can have another review performed by an administrative law judge depending on the size of the claim(s).

Oversight and Regulation of Medicare Advantage Plans

Both CMS and states have defined responsibilities for the oversight and regulation of MA health plans. Deemed compliance is also part of the oversight process, but only through

monitoring. CMS and states have the sole authority to regulate or take necessary actions within the scope of their responsibilities. Federal and state oversight responsibilities are briefly described next.

Federal Regulation of MA Plans

As mentioned earlier, the MMA expanded existing federal preemption of state law over MA plans for many operational (but not financial) aspects, making CMS responsible for a substantial number of laws and regulations with which MA plans must comply, including but not limited to:

- The bid process
- CMS and member premium payment
- The HCC program for risk adjustments
- Network adequacy and access
- Allowable and prohibited marketing and sales practices
- Broker and agent certification to sell MA products (but not licensure, which is the responsibility of the state)
- Quality measures
- Coverage determinations
- Medicare fraud and abuse

CMS can and does intervene with MA plans when it determines that certain requirements are not being met. Potential actions and sanctions can include an increased reporting schedule, the imposition of a performance improvement plan, suspension or limitation on an MA plan's ability to market and sell, fines and penalties, and even suspension or revocation of an MA plans participation in the MA program.

State Regulation of MA Plans

The MMA did not preempt states for regulating licensure and solvency of MA plans, and for regulation, licensure, and market conduct of brokers, agents, and producers. Because federal law requires MA plans to bear the risk for the medical costs of its MA enrollees, MA plans are required to be a risk-bearing entity licensed by the states in which they do business, and to meet the states' solvency requirements as described in Chapter 6. The risk-based capital calculations performed to determine statutory capital in MA plans include criteria specific to the nature of MA.

Potential actions and sanctions that states may impose on MA plans include an increased financial reporting schedule, the imposition of a financial performance improvement plan, suspension or limitation on an MA plan's ability to market and sell any products, imposition of fines and penalties, increased state oversight (including an onsite presence) and approval requirements for plan spending for other than claims payment, mandatory plan rehabilitation, and seizure of the plan and suspension or revocation of its license or COA.

Corporate Compliance

Corporate compliance activities are directed toward (1) ensuring that the organization conforms to legal and regulatory requirements and (2) preventing and detecting illegal behavior. Corporate compliance applies to all payers under a variety of laws and regulations, including Medicare. Because there is considerable overlap, it is permissible and practical to combine the corporate compliance activities for most or all of the different laws and regulations into one overall compliance function.

For MA plans specifically, CMS, through the Office of the Inspector General, has created corporate compliance guidelines that an MA plan must follow. The full set of corporate compliance requirements is, as you would expect, lengthy and complex, but in general an effective MA corporate compliance program includes:

- Creation of a special compliance committee
- Designation of a corporate compliance officer

- Creation of standards of conduct for employees
- Creation of policies and procedures specifically designed to ensure compliance with MA rules
- Special training for employees
- Employee surveys that focus on compliance issues
- A hotline for employees to report violations of MA rules
- Exit interviews of employees in which they are asked about possible rule violations
- Audits of compliance
- Screening for individuals or entities barred from participation in federal programs (applies to employees, providers, and vendors)
- Creation of an internal investigation program that focuses on MA rule violations

Medicaid

Medicaid and Medicare were passed at the same time, and Medicaid is the entitlement program that provides benefits coverage to eligible low-income individuals and families as well as some individuals who meet other criteria listed below. Medicaid covers more people than Medicare does. The Medicaid program was used to increase coverage for children through the State Children's Health Insurance Program (SCHIP or simply CHIP), but CHIP is not technically a Medicaid entitlement and is not a permanent entitlement. Regardless, CHIP is run through states' Medicaid departments or agencies, and it must periodically be reauthorized by Congress.

Unlike Medicare, Medicaid is administered by the states, although a little less than two-thirds of its funding on average comes from the federal government.* To receive federal funds, states must pass laws that require their Medicaid program to follow federal laws and regulations that apply to Medicaid. While states may not reduce eligibility or coverage from the federal minimal baseline, they may increase them. For that reason, some aspects of eligibility, coverage, payment, and services may vary from state to state.

Many Medicaid beneficiaries are, at present, only covered through their state's traditional FFS Medicaid program—for example, individuals in nursing homes and individuals living in an area that does not have a managed Medicaid plan. But as pointed out earlier in Chapter 1, states have become reliant on private managed Medicaid plans to manage costs and access, and improve health outcomes, and they now cover most Medicaid beneficiaries in each state. Private managed Medicaid plans may be nonprofit or for-profit, stand-alone or subsidiaries of a larger plan or organization.

Eligibility for Coverage

Basic eligibility for coverage under Medicaid is a complex topic and will only be described here at a very high level. Medicaid eligibility follows two sets of rules. One set applies to Medicaid programs in all states. The other set applies to state Medicaid expansion under the ACA, which not all states have undertaken. As noted earlier, some people, often referred to as duals, are eligible for both Medicare and Medicaid, and this topic is discussed in the chapter's last section.

Eligibility for Medicaid Coverage in Nonexpansion States

Not including the expansion provisions in the ACA (discussed shortly), states must cover a core group of people with incomes below specified minimum thresholds based on a percentage of the federal poverty level (FPL).

* The percentage varies from state to state based on a variety of factors, and ranges from over 75% (7 states) to 50% (3 states).

The dollar amount of the FPL is determined annually and increases by family size. In 2019, for example, it was $12,140 for individuals and $4,320 is added for each additional family member. The minimum level of income eligible for Medicaid in nonexpansion states averages only 44% of the FPL. The ACA modified the process for eligibility determinations in Medicaid to be consistent with eligibility determinations for premium and cost-sharing assistance in insurance exchanges (Chapter 6) by basing it on Modified Adjusted Gross Income or MAGI, but as a practical matter the description in this book is adequate.

In all states, core eligibility includes four types of low-income individuals:

1. Children and pregnant women
2. Parents, but not to the same degree as children and often limited to mothers in nonexpansion states
3. Elderly individuals needing nursing home care who are either impoverished at the time of their admission or become so by "spending down" and becoming "medically needy"
4. Certain individuals with disabilities, including those who are institutionalized

Individuals who receive Supplementary Social Security benefits and children who are in foster care automatically qualify for Medicaid by being in those programs.

Dual eligibles, or duals, were briefly discussed earlier in the section on Medicare. Duals are usually eligible for Medicaid as one or both of the last two core groups. Most direct coverage for duals comes through Medicare, including coverage of prescription drugs, with Medicaid covering Medicaid-specific benefits not covered by Medicare; care in an intermediate nursing care facility, for example. There is also a form of partial dual coverage without direct Medicaid benefits, but in which Medicaid pays for Medicare premiums, cost sharing, or both.

Eligibility for coverage of children is broader than for their parents because the CHIP program provides coverage to children in families with incomes that are low, but not necessarily low enough to qualify for Medicaid.

Low income alone does not make someone eligible in all states. Nonelderly adults without dependent children, referred to as childless adults, are generally not considered eligible for traditional Medicaid coverage in states that have not expanded Medicaid coverage under the ACA.

Only American citizens and specific categories of lawfully present immigrants (called qualified non-citizens by CMS) can qualify for Medicaid, and most lawfully present immigrants cannot qualify for coverage for the first 5 years they reside in the United States. The states can eliminate that waiting period for lawfully present children and/or pregnant women, but not for other adult immigrants.

The ACA greatly simplified the process for determining and maintaining eligibility. Finally, at the time of publication, the federal government was allowing states to implement work requirements for those able to work or seek work in order to maintain eligibility.

Medicaid Expansion Under the ACA

In addition to expanding access to coverage and subsidies to those who qualify through reforms in the commercial market, the ACA sought to broaden the number of people who would be eligible for coverage under Medicaid by overriding each state's differing rules for who is or is not eligible for coverage. It set a standard of eligibility as a MAGI at or below 138% of the FPL, above which individuals and families would be eligible for subsidized premium credits for coverage through private plans sold through the health insurance exchanges (see Chapters 2 and 6).

The cost for the expansion was 100% paid for by the federal government until 2017, when the federal government's share began to slowly

decline until 2020, after which the federal government pays 90% of the cost associated with the coverage expansion. The amount of the federal subsidy to states is based on a relatively low level of eligibility prior to expansion applied uniformly to an expansion state; in this way, the ACA does not short-change states that had already established more generous eligibility standards.

Medicaid expansion under the ACA was significantly affected when the 2012 ruling by the U.S. Supreme Court that determined the ACA was constitutional also ruled that states were not required to accept the Medicaid expansion, and that not expanding Medicaid would not change how much federal money the states received under their existing programs. Of course, not expanding Medicaid also meant that a state would not receive any funding related to expansion.

At the time of this text's publication, 37 states including the District of Columbia had expanded Medicaid eligibility under the ACA.* Some other states were considering it, but nothing is certain. There is no deadline for states to adopt expansion, so more states may expand their coverage over time.

In states that have not expanded coverage, anyone who has an income that is greater than that state's cutoff for Medicaid eligibility but less than 133% of the FPL is not eligible for coverage under Medicaid, but also not eligible for any premium subsidy for private coverage under the ACA, leaving those people without any affordable means to obtain coverage.

Identification of Eligible Individuals and Families

The existence of eligibility is one thing; being able to know if somebody is eligible is another. Many individuals who qualify for Medicaid coverage qualify because of medical and/or mental health problems that hinder their ability to navigate in the world, or how to apply for coverage, or sometimes even knowing that they can. Such individuals are often identified when they present to a hospital's emergency department, at which point a knowledgeable hospital employee or social services representative gets them into the Medicaid system. In states that immediately assign recipients to a managed care plan, it becomes a challenge to begin CM in the midst of an urgent or emergency admission on a new member who may not be in a good position to understand.

Churning

One of the most frustrating eligibility-related administrative concerns for Medicaid managed care plans is member turnover due to changes in eligibility, commonly referred to as churning. This occurs most often because a person's income increases enough for that individual to lose eligibility, though it is less of an issue for CHIP. Churning used to occur on a monthly basis, but over the last 10 years, Congress has passed laws that provide some stability by extending periods of eligibility before redetermination is required. The ACA provided even more stability for expansion states.

Churning can also occur when an individual has a small increase in income that pushes them from Medicaid eligibility to subsidized coverage through a health insurance exchange. It can also go the other way. The ACA requires exchanges to help such persons make a seamless transition to subsidized commercial coverage, but it is a difficult area to track and is not even an option for some low-income people in those states that did not expand Medicaid eligibility.

* The most recent states are Virginia, where expansion passed in 2018 for an effective date of 2019; and Idaho (where it was being challenged in court at the time this was written), Nebraska, and Utah that expanded Medicaid through voter referendums in November 2018.

Eligibility Renewals and Maintenance

Unlike Medicare, in which once one is eligible for coverage one keeps it, Medicaid eligibility can come and go based on things such as income levels, changes in family composition, becoming eligible for coverage through another source, moving out-of-state, failing to meet work requirements in those states allowed to impose them, commission of a crime and incarceration, or simply disappearing. Of course, not all beneficiaries are potentially subject to all of those potential causes, and some beneficiaries are rarely if ever at risk of losing coverage.

For this reason, states perform periodic eligibility checks and may make a retroactive adjustment in coverage. Some who qualify for Medicaid do not have a permanent address or telephone number, or even another person that may be contacted as needed. States and private managed care plans have developed techniques for operating in this environment, but it can contribute to churning nevertheless.

Medicaid Benefits

Medicaid benefits include the usual benefits of commercial coverage, but usually also cover additional services, such as:

- Transportation
- Speech, hearing, and language disorder services
- Optometry services
- Eyeglasses
- Dental services and dentures
- Prosthetics
- Nursing home and community-based long-term care
- Hospice
- State Plan Home and Community-Based Services
- Self-Directed Personal Assistance Services
- Community First Choice Options

In addition to the preventive benefits available under the ACA, Medicaid requires coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals younger than age 21. Prescriptions drugs are technically an optional benefit but are nevertheless covered by states, though not to a uniform degree. States can require some beneficiaries to pay a small premium as well as some level of cost-sharing, but the amount of cost sharing is limited; there is some evidence that even a small amount of out-of-pocket costs can deter Medicaid beneficiaries from obtaining necessary care.

Federal Medicaid Managed Care Authorities

The traditional Medicaid program as passed is strictly FFS, and FFS is the default Medicaid program even today. For states to implement managed care, the state must first apply for and obtain a federal waiver issued under one of four basic types of federal authorities.* Some states apply for a single type of waiver, but many states apply for multiple waiver types so they can implement more than one type of managed care program. Before a state can implement any managed care plan, it must be first approved by CMS, and all but one require periodic renewal.

Three of the authorities are considered waivers because they waive the state's requirement to comply with certain aspects of the traditional FFS program. The other is closer to delegating that authority to the state. In all cases, CMS requires states receiving waivers to contract only with managed care plans that have a QM program, provide reasonable access to

* A federal authority refers here not to a U.S. Marshall or an FBI Special Agent, but to a provision under federal laws and regulations that gives a federal agency the authority for something.

providers, ensure that beneficiaries have a right to change managed care plans when possible, and that the state ensures enrollees' appeal and grievance rights. The four authorities authorizing states to use managed Medicaid plans are:

Section 1932(a) State Plan Authority. This allows a state to seek approval for a state-wide managed care program run either by the state itself, or by one or more contracted managed care companies, and is not restricted by type of plan. Under this authority, states cannot require dual eligibles, American Indians, or children with special healthcare needs to enroll in a managed care program. Section 1932(a) authority does not need to be renewed once it is granted.

Section 1915(a) Waiver Authority. This waiver allows states to put a voluntary managed care program in place by contracting with companies through a competitive bid process. It must be periodically renewed.

Section 1915(b) Waiver Authority. There are several types of Section 1915(b) waivers that range from one that restricts which providers beneficiaries may use, to one that uses cost savings to fund additional benefits. Unlike a Section 1932(a) State Plan, the state may require dual eligibles, American Indians, and children with special healthcare needs to enroll in a managed care plan. It must be periodically renewed.

Section 1115 Waiver Authority. This commonly used waiver allows states to use experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. It allows for more state flexibility to design and improve their Medicaid programs to increase eligibility, improve benefits, and/or innovate. It must be periodically renewed.

Types of Managed Medicaid Plans

Most Medicaid beneficiaries are currently enrolled in managed Medicaid programs or plans. There are five main types of managed Medicaid plans, of which all but the first are usually operated by private companies or organizations:

1. The primary care case manager (PCCM) plan
2. Limited benefits plans
3. Comprehensive risk-based plans
4. D-SNPs that were addressed earlier in the section on Medicare
5. Managed Long-Term Services and Supports (MLTSS) plans that are risk-based plans for long-term services

Primary Care Case Manager Plan

In a PCCM plan, primary care physicians (PCPs) are paid a monthly fee to manage the care of their Medicaid patients. Beneficiaries are not locked in to seeing only the PCP, however. Providers, including PCPs, are paid through traditional FFS and there is no provider risk sharing. The service area for PCCMs typically covers the entire state, and this type of coverage may be the default plan if a compressive plan is not available.

PCCM plans may be run by the state, as a program rather than a type of plan but not always. A state may contract with a private company to administer it. Some but not all privately run PCCM plans share at least some level of financial risk with the state. In recent years, states have been moving away from PCCM models because they do not provide the same value that comprehensive plans provide.

Limited Benefits Plans

Limited benefits plans manage a subset of benefits, such as transportation or behavioral health services, or for special needs populations, such as children in foster care or developmentally delayed children. Limited benefits plans may be paid on a risk basis or may be paid a management fee only. They can include prepaid inpatient health benefits plans, ambulatory benefits, or both.

Comprehensive Risk-Based Plans

Although it varies by state, most Medicaid managed care plans are comprehensive risk-based plans, meaning the plan is at risk for most costs. It is common for states to carve out specific benefits, even when contracting with comprehensive plans. Most commonly this is done by contracting with limited benefits plans for behavioral health and substance abuse services, pharmacy benefits, transportation, DME, and so forth.

State Medicaid agencies employ multiple approaches to select which companies they will contract with. Some states establish participation qualifications for interested plans—including payment rates—and select all plans that meet them. Most require periodic rebidding.

At the time of publication, all states except Alaska and Wyoming have all or some Medicaid beneficiaries in some form of managed care plan. But there are many different state contracting configurations. Some states contract with multiple qualified plans to operate in the same area(s) and in that way, compete to the limited degree possible. Other states may award only a limited number of contracts, or contract only with a single company to cover a specific geographic area. In some cases, such as rural or semirural areas, there may only be a single plan—or sometimes no plan—willing to contract regardless of the ability for more than one to operate there.

Over the years, states have become more detailed and demanding in their contracting with health plans over key requirements like provider network access standards, customer service standards and obligations, performance data submission, external reviews, and many other criteria that must be met to merit a contract. CMS has also issued standards and requirements for many of these things.

Managed Long-Term Services and Supports Plans

MLTSS plans are risk-based plans that focus on long-term services and supports. They may include D-SNPS, Medicaid beneficiaries with special needs, and/or those requiring other long-term care and assistance. Like the most Medicaid managed care plans, MLTSS plans are based on a waiver, but unlike the comprehensive risk-based plans that exist in nearly all the states, far fewer states have received MLTSS waivers or contracted with plans.

States use MLTSS plans as a way of expanding home- and community-based services, managing quality, and increasing efficiency. States manage who is eligible to be in an MLTSS plan and may expand eligibility to people with functional needs who are at risk of institutionalization in order to maintain beneficiaries in their homes and prevent the need for costlier, more intensive future services.

Sales and Marketing

All of the regulations created by CMS for MA plans that apply to sales and marketing and were described earlier in the chapter, apply equally to managed Medicaid plans, but states are free to apply additional requirements as long as they do not violate the federal regulations. Many states allow no sales or marketing by plans, especially those states that contract with only one plan per region. In states where beneficiaries may have a choice, plans may undertake acceptable forms of outreach, such as attendance at meetings, returning calls, and the like. Cultural diversity is very important in Medicaid plans, including the need to accommodate non-English-speaking individuals. Because of the low educational levels present in some Medicaid populations, materials that explain the program must be written in easy-to-understand language.

Enrollment

Most states currently require low-income women and children to be enrolled in a Medicaid comprehensive plan (or PCCM if no comprehensive plan is available) and may do so for other types of beneficiaries as well.

Enrollment may be voluntary in some cases, or a mix of voluntary and mandatory, but most states have moved to mandatory enrollment. Beneficiaries may be able to choose the plan in which they will enroll if there is more than one available. When options are available, beneficiaries who do not choose a plan may be automatically assigned to one of the managed care plans or to the PCCM plan. Federal laws and regulations require that states allow enrollees in a mandatory managed care program the right to change plans, if there are other plans available, within 90 days of enrolling and every 12 months after that. Like any HMO, Medicaid comprehensive managed care plans can enroll only members who live within the plan's service area.

Some states contract with independent enrollment brokers to assist beneficiaries with the selection and enrollment process, and as of 2018, all states are required to provide independent choice counseling services for all new managed care enrollees and all enrollees who are changing health plans. States may also use community-based organizations to assist enrollees with the enrollment process, which is not the same as a plan's outreach efforts that are more directly related to sales.

The ACA created a requirement for the health insurance exchanges for the individual market to provide a seamless entry point or transition for individuals eligible for Medicaid as well as commercial health insurance. This generally works, but has experienced some challenges in some states.

Payment of Managed Medicaid Plans

Risk-based limited benefits plans and comprehensive managed Medicaid plans are almost always structured as HMOs and are paid by the state through a per member per month capitation. However, what is being called "capitation" in reference to payment of private plans is closer to a premium payment than it is to provider capitation that was described in Chapter 4. It is called capitation because Medicaid is not technically insurance so payment to a plan is a form of prepaid benefits.

Prior to 2002, states were prohibited from paying more than the equivalent of costs to the Medicaid FFS program. That changed, however, because as states moved more heavily to contracting with comprehensive managed care plans, what FFS data remained was no longer useful for comparisons, plus beneficiaries in the FFS program often did not get the same level of preventive services that those in managed care plans received.

Plan payment capitation rates are typically computed by states in ways similar to what is used to calculate commercial premium rates (see Chapter 6), adjusted for differences in benefits and Medicaid-specific trends and requirements. As of 2018, states must also ensure that plan capitation rates are adequate for the plan to meet its contractual requirements, such as accessibility of providers and services, QM, and coordination and continuity of care. As of 2019, payment must have the same 85% MLR limitations on managed Medicaid plans that are in place for commercial health insurance plans and MA plans. States must send data to CMS for periodic review of their rate-setting processes. Finally, some states have begun applying risk adjustments like those used by CMS for payment of MA plans, but they are usually less complicated, at least for now.

Medical Management in Managed Medicaid Plans

Medicaid managed care is a demanding line of business, requiring plans to serve populations with complex medical and social needs and forcing them to develop provider networks of considerable diversity—in terms of both service capabilities and cultural competencies. UM, CM, DM, and QM in Medicaid plans are similar to the programs used in MA plans but must accommodate the differences in this

population. They must also meet prevention standards that apply only to Medicaid and CHIP, such as the EPSDT program mentioned earlier.

Medicaid plans have to address a number of special challenges, of which only a few examples follow to illustrate this. As a group, adult Medicaid beneficiaries are more likely to smoke cigarettes and abuse alcohol and/or other drugs, so treatment and prevention programs must be more proactive and must incorporate the socioeconomic pressures facing many of their members. At the time of publication, the epidemic of opioid abuse that has affected all segments of the population has hit the Medicaid population particularly hard, and in some states the combination of the state, the private managed Medicaid plans, and sometimes the federal government have placed concentrated efforts in combatting it.

Other examples of special challenges include the high concentration of high-risk pregnancies in the Medicaid population, and higher than average rates of chronic conditions like asthma, diabetes, depression, and behavioral health problems, requiring well-planned interventions to promote member well-being and to achieve cost-effective outcomes. Many beneficiaries face difficulty meeting a healthy diet, which negatively affects pregnancies and all chronic conditions. Lack of transportation is often a major factor in the ability of beneficiaries to even see a provider. Finally, following up with Medicaid members can sometimes be a challenge because many enrollees have no permanent address or a consistent telephone number, something we also saw affecting re-eligibility determinations.

Oversight and Regulation of Medicaid Managed Care Plans

Unlike MA plans, state managed Medicaid plans are not preempted by the MMA, although states are required to comply with Medicaid-related federal laws and regulations as a condition of federal funding. The federal government generally does not directly regulate managed Medicaid plans, but requires states to do so in accordance with federal regulations. States monitor the activities of Medicaid plans in much the same way that the federal government monitors the activities of MA plans, and they provide data to CMS.

Like MA plans, accreditation by NCQA means a managed Medicaid plan is deemed to compliant with multiple standards as described for early for MA. Plans are also required to submit HEDIS and CAHPS data. As applied to managed Medicaid plans, accreditation, and HEDIS and CAHPS data include measures and metrics that are specific to Medicaid.

Conclusion

Medicare and Medicaid are entitlement healthcare programs, one of which is managed at the federal level and the other by states. Together they represent enormous expenditures of U.S. and state tax dollars. Medicare, by implementing managed care through MA, has been able to better measure and manage certain aspects of quality of care, improve its healthcare benefits, and better realize the value of the money it spends. The creation of the Part D drug benefit provided greater benefits to those persons who enroll in that program, and managing this benefit has also become a major area of focus for managed care, just as it is for commercial health plans.

State Medicaid programs have successfully used managed care to manage costs, improve access, and enhance the coordination of care, which explains why all but two states have incorporated managed care into their Medicaid programs. The ACA contains provisions for the expansion of Medicaid

eligibility as part of its overall goal of increasing coverage, but because of a ruling by the U.S. Supreme Court, states can choose to not expand Medicaid coverage; some states chose to not expand.

Because Medicare and Medicaid are government entitlement programs that have specific types of populations and specific types of needs and challenges, as well as a bounty of specific regulations, payers that undertake to serve Medicare and/or Medicaid populations must be prepared to focus or modify their operations to meet the programs' special requirements.

CHAPTER 8

Laws and Regulations in Health Insurance and Managed Care

Tom Wilder, JD

LEARNING OBJECTIVES

- Describe the basic structure of state and federal oversight of managed care organizations (MCOs).
- Identify key state and federal laws and regulations governing managed care.
- Explain the interaction of state and federal laws affecting health plans and payers, including preemption and the role of the courts.
- Demonstrate an understanding of the role of nongovernmental organizations in the oversight and regulation of payer organizations.

Introduction

Traditionally, states have regulated health insurers, preferred provider organizations (PPOs), and health maintenance organizations (HMOs), referred to collectively as MCOs. State oversight traces its origins to the enactment of the McCarran-Ferguson Act by the U.S. Congress in 1945; this act gave states the authority to oversee insurance products, including health coverage. As more individuals and employers purchased health insurance, states began passing laws regulating managed care. The laws covered issues, such as the following:

- Establishing solvency requirements, also referred to as statutory net worth
- Requiring coverage for certain medical conditions, also referred to as mandated benefits
- Establishing requirements for health-care provider networks, also referred to as access requirements or network adequacy

NOTE TO THE READER

This chapter uses the acronym MCO, meaning Managed Care Organization, for managed care payers of all types. MCO is not otherwise used in this book, but it often appears in language used in laws and regulations, so it is used here as well.

Many of the topics covered in this chapter are discussed in greater or lesser detail in other chapters as well, but usually only as they apply to a specific type of operations. This chapter brings them all together to provide the overall framework for laws and regulations of health insurers and MCOs. Cross-references to other chapters are not supplied in this chapter, but the reader should have no difficulty locating relevant material elsewhere in the book as needed.

One important federal law, the Medicare Modernization Act (MMA) of 2003, also has a significant impact on private Medicare Advantage (MA) plans, as well as providing beneficiaries with an optional drug benefit administered by private companies. However, because the MMA was covered in Chapter 7, it is omitted from this chapter.

- Setting standards for medical review of claims, including appeals of benefits coverage denials
- Standards for licensing MCOs and insurance agents
- Other consumer protections, such as laws protecting the privacy of health information

Increasingly, MCOs and managed care are subject to federal laws and regulations in addition to state oversight. Starting with the passage of the HMO Act in 1973, Congress and the federal regulatory agencies have played a significant role in how managed care is provided. Laws, such as the Employee Retirement Income Security Act (ERISA), Health Insurance Portability and Accountability Act (HIPAA), and the Patient Protection and Affordable Care Act (ACA) have vastly expanded federal regulation of MCOs.

There is a great degree of interaction between state and federal laws and regulations. For example, the insurance market reform provisions of HIPAA were based in large part on existing state laws regulating insurance. Similarly, many of the requirements in the ACA enacted in 2010 modified state laws and regulations affecting MCOs and managed care.

This chapter provides an overview of the state and federal agencies regulating MCOs, discusses the key state and federal laws and regulations on managed care, and explains what happens when state and federal laws governing MCOs and managed care conflict. It also discusses the key role played by the courts and by certain types of nongovernmental organizations—such as the National Association of Insurance Commissioners (NAIC)—in setting standards for MCOs. It should be understood, however, that state and federal laws on managed care are evolving. While this chapter provides a general understanding of how MCOs are regulated at the time of publication, up-to-date resources should be consulted for legal or compliance guidance. This advice also applies because any and all laws and regulations are subject to potential change; this has especially been the case with the ACA in the 2 years immediately before this chapter was written.

MCO Structure and Organization

All health insurers use managed care techniques to one degree or another in providing health coverage. While this chapter discusses state and federal regulation of MCOs, the same laws and regulations apply equally to other types of health insurers. MCOs are

typically divided into several broad types of structures:

- HMOs, which provide coverage of physician services either directly as a closed panel plan (group or staff model) or through a network of contracted physicians as an open panel plan (independent practice association or direct contract model). Enrollees must receive care from one of the physicians or hospitals participating in the HMO network. In the HMO structure, members usually must select a primary care physician (PCP), who is then responsible for the individual's care and who must approve any referral of a patient for services provided by a specialist provider.
- Point-of-service (POS) plans, which have the structure of an HMO but also cover some level of out-of-network care. The enrollee is responsible for the cost that is not paid by the POS plan.
- PPOs, which provide coverage through a contracted network, but also cover services obtained on an out-of-network basis. Medical services outside the PPO network will be paid at a lower rate by the MCO, with the enrollee being responsible for any cost difference.
- High-deductible health plans (HDHPs) and HDHPs with optional pretax savings accounts such as consumer-directed health plans using either a health savings account (HSA) or healthcare reimbursement arrangement (HRA).

MCOs and other health insurers provide coverage in three distinct markets: (1) insurance coverage purchased by individuals, (2) group coverage provided by employers and/or labor unions and paid for by employer and employee premiums, and (3) government entitlement programs, such as Medicaid and Medicare.* This chapter discusses state and federal regulation of the individual insurance market and coverage provided to groups; Medicare and Medicaid are discussed in Chapter 7.

State Oversight and Regulation

State oversight of MCOs, other than of self-funded plans that are addressed later in the chapter, generally focuses on two aspects of health care: how managed care is provided to individuals and what MCOs can and cannot do in carrying out their business operations. Most of the state regulation is carried out through the Department of Insurance. In some states, the Department of Health or Department of Managed Health Care may be responsible for regulating HMOs. For example, the California Department of Managed Health Care oversees HMOs, and in Pennsylvania, the Department of Health has primary responsibility for HMO oversight.

At a basic level, state laws and regulations are intended to make sure individuals get the health coverage they pay for. These laws establish a wide range of managed care standards and requirements for MCOs.

Licensing MCOs

States typically require MCOs to conform to licensing requirements geared toward ensuring the MCO has sufficient management expertise, adequate financial support, and sufficient healthcare provider networks to do business. MCOs must obtain state approval to engage in operations and provide health coverage. For health insurers and any types of MCOs operated by a health insurer, state approval comes

* Benefits plans for governmental employees and elected officials are employer-based group coverage, not entitlement programs.

through an insurance license; for HMOs and any HMO-based MCOs (e.g., most POS plans), state approval comes through a certificate of authority. States also regulate any holding company that owns or controls the MCO and any subsidiaries of the MCO.

In addition, the state licenses insurance agents and brokers who sell insurance coverage on behalf of the MCO to individuals and employers. The agent and broker licensing requirements address compensation paid to the agent or broker, education and training, and consumer protections. States may also require agents and brokers to post a bond or other evidence of financial responsibility as a condition of doing business.

Informing Consumers

States have established extensive requirements for information given to individuals when they enroll in coverage provided by an MCO. MCOs must provide enrollees with an evidence of coverage (EOC) document that contains information about what is and is not covered, any requirements for preapproval of medical services, the healthcare professionals and hospitals that are in the MCO's provider network, procedures for filing grievances, and conditions under which the individual will be expected to pay part of the cost for medical care. States also control the language included in the application for coverage submitted by the individual or employer. Almost all states require the MCO to submit insurance forms and applications for preapproval prior to use.

In addition, states have laws and regulations requiring MCOs to provide an explanation of benefits (EOB) form to individuals after a claim is submitted. The EOB describes the name of the doctor or hospital, the medical services that were provided, the cost for the services, and the portions of that cost that are the responsibility of the MCO and the individual. The EOB must also disclose information on any denied claims and the individual's rights to appeal if the claim is not paid in full or in part by the MCO (for example, if the claim is denied because the MCO does not believe the service was medically necessary).

Protecting Health Information Privacy

Consistent with HIPAA, state laws require MCOs to protect the privacy of any health information that is collected, used, or shared by the MCO. These laws typically give the MCO the right to use the individual's health information without consent for purposes of providing medical care or for carrying out business operations, such as paying claims. Many state laws provide specific protection for certain types of sensitive information, such as behavioral health conditions, substance abuse disorders, and sexually transmitted diseases. In addition, laws and regulations require MCOs to provide data security protections and to inform individuals if their information is compromised.

Requiring Coverage for Care from Medical Professionals and for Medical Conditions

Almost all states have laws requiring MCOs to cover specified medical conditions (e.g., breast cancer, substance abuse disorders, behavioral health conditions), certain categories of medical providers (e.g., chiropractors, midwives, physician assistants), and medical services (e.g., bone marrow transplants, maternity care, hearing aids). These mandated benefits vary from state to state. The laws are intended to make sure patients have access to a full range of healthcare benefits from the MCO. MCOs are permitted, however, to determine whether a mandated benefit or service is medically necessary before providing coverage, and to set credentialing requirements for network providers.

Overseeing Utilization Review and Quality Assurance

Utilization review (UR), also called utilization management, is the process used by MCOs to determine if a covered medical service is medically necessary and, as a result, is a covered benefit. Typically, the MCO will use nationally recognized medical guidelines and input from healthcare provider specialists to develop medical necessity review standards for various types of services. In some cases, the MCO will require a patient to get prior authorization before an elective service is provided; in other situations, retrospective review may be applied. Almost all states have laws and regulations governing the situations in which UR may be used by the MCO and the qualifications of any healthcare providers used by the MCO to determine if the service is medically necessary.

Most states also require MCOs to have a quality assurance (QA) program, also referred to as a quality management (QM) program. The most common types of MCO that are required to have a QA/QM program are HMOs and HMO-based POS plans. Some states also require PPOs to have one. The definition of an acceptable QA/QM program varies from state to state, and many states default to the standards set by a health plan accreditation organization.

Contracting with Healthcare Providers

MCOs contract with physicians and hospitals to provide services to enrollees. State laws and regulations govern healthcare provider networks and contracts between the MCO and the providers. These laws address how disputes between the provider and the MCO must be handled, how quickly claims from the provider must be paid (and penalties for late payment), and when an MCO is allowed to drop a provider from the network. In addition, a number of states have passed "any willing provider" laws that require the MCO to accept any healthcare provider who is willing to accept the terms and conditions of the network.

Assuring Adequate Provider Networks

Most states have network adequacy laws requiring MCOs to have sufficient healthcare providers available for enrollees. Network adequacy, also called network access, is typically measured based on the ratio of healthcare providers to enrollees, the location of a physician's office or inpatient facility in relation to the enrollee, and waiting times for appointments. In addition, a number of states have laws mandating that HMOs that require an enrollee to designate a PCP must allow the individual to designate any healthcare provider or specialist as his or her PCP.

Protection Against Balance Billing

Most MCOs use a contracted provider network to deliver care to the plan's enrollees. In turn, states typically have laws requiring MCOs' provider contracts to include language prohibiting the provider from requiring patients to pay any amount of the cost for medical services not paid by the MCO except for any copayments or coinsurance specified in the EOC document. If an enrollee goes outside the network for care, he or she will end up paying more of the cost for those services because the provider has no contract with the plan.

Assuring a Fair Insurance Market

State insurance market rules govern how much the MCO can charge in insurance premiums for coverage offered to individuals and employers. The laws generally divide the market into three segments: (1) coverage sold to individuals,

(2) coverage offered to small employers (generally, businesses with 1–50 employees), and (3) coverage offered to large employers (businesses with more than 50 employees). The insurance market rules typically apply the following standards to MCOs when establishing insurance premium rates and offering coverage to individuals and employers:

- Guaranteed availability: The health coverage must be provided to all individuals and employers that want to purchase coverage, although this ability may be limited to designated open enrollment periods.
- Guaranteed renewability: The MCO is required to renew health coverage provided to individuals and employers for another year unless the individual or employer fails to pay premiums or has engaged in fraud.
- No preexisting condition exclusions: The MCO cannot exclude or limit coverage for any medical conditions (e.g., diabetes or cancer) that the individual had when he or she enrolled in coverage.
- Rating factors: MCOs are prohibited from varying the cost of coverage except for factors based on the age of the individual, family composition (e.g., self-only versus family coverage), and the individual's participation in a wellness program (e.g., some MCOs may provide a premium credit if the enrollee successfully completes a tobacco cessation program).
- Limits on rating: States set limits on the premiums that can be charged by an MCO in the individual and small group markets. States typically take one of three approaches to the insurance market: (1) a pure community rating, in which all individuals or groups are charged the same rate; (2) an adjusted community rating, in which rates may vary based on demographic or other factors; and (3) rating bands, where rates may vary for individuals or groups based on a percentage factor. With the last approach, for example, rates charged to small businesses might be allowed to vary no more than 20% between the lowest premium and the highest premium charged by the MCO for coverage in the market. The ACA includes limits as well; for example, the highest age band can cost no more than three times the lowest.
- Nondiscrimination: MCOs may not charge individuals more for coverage based on a health status factor, such as their health condition, disability, or prior medical history.
- Preapproval of premium rates: Most states require MCOs to submit rates in advance to the state Insurance Department, Department of Health, or Department of Managed Care for approval prior to use.
- Continuation of coverage: Most states require MCOs to offer individuals who lose coverage through an employer the opportunity to purchase coverage in the individual insurance market (these requirements are typically limited to businesses with fewer than 20 employees because federal ERISA continuation coverage requirements apply to employers with 20 or more employees).

Assuring MCO Solvency

As seen earlier in Chapter 6, states typically require MCOs to meet solvency standards, thereby assuring that the MCO has sufficient financial resources available to pay medical claims for members for which the plan, not the employer, is at risk. This requirement is also called statutory net worth or sometimes statutory reserves. The state laws establish rules that require MCOs to submit quarterly and annual financial reports, including the amount of surplus financial capital the MCO must have available at all times, as determined under statutory accounting principles (SAP), based on risk-based capital levels.

States have the authority to examine the accounting and financial records of MCOs and to take action if an MCO's statutory surplus levels fall too low. When the statutory surplus falls to a certain level but is still higher than the statutory minimum, a state has the right to intervene and place specific demands on the MCO for improving its surplus within a set period of time. If an MCO's surplus levels fall too low, the state has the authority to take over the MCO. At that point, it may attempt to rehabilitate the MCO, but it is far more likely that the state will seek to sell the troubled MCO to another, healthier plan. Failing that, the state may be left with the prospect of dissolving the MCO and distributing its members to other plans in the same service area. Many states have a guarantee fund that is available to pay the claims of MCOs that have been dissolved; the guarantee funds are subsidized by MCOs and other health insurers doing business in the state. These guarantee funds, however, typically do not include HMOs although some states are now changing their laws to cover HMOs.

Assessing Market Conduct

Market conduct involves the state's regulation of MCO practices that directly affect consumers—for example, marketing, advertising, sales practices, and language used in documents provided by the MCO to prospective purchasers and enrollees. Many states have enacted laws prohibiting unfair or deceptive trade practices, such as not promptly handling a claim for benefits or engaging in misleading advertising. State insurance regulatory agencies will periodically carry out market conduct examinations at MCOs to review how complaints are handled, how products are marketed and sold, and other processes affecting consumers.

Resolving Enrollee Grievances and Appeals

State laws dictate how MCOs must resolve grievances with an enrollee as well as enrollee appeals of benefits denials. Grievances are formal complaints by enrollees that do not include a denial of benefits coverage. MCOs typically must respond to formal grievances in writing. State laws and regulations for appeals and grievances must comply with ACA requirements as described in Chapter 6, or else the ACA requirements take precedence.

Laws about appeals of benefits denials typically provide for additional review of the claim, establish the time limits for review, and permit the individual or his or her physician to present additional documentation on why the medical service should be covered. This process is called an internal review. If the appeal involves a denial of a medical benefit based on medical necessity, the MCO reviewer must have specific training and expertise in the service that is being appealed—for example, a cancer specialist must review appeals involving benefits denials related to services for cancer.

If the MCO and the enrollee are not able to resolve the appeal of a medical claim where the denial is based on a determination by the MCO that the service was not medically necessary, the dispute may be submitted to an independent review organization (IRO)* that will determine whether the individual is entitled to coverage. This process is called an external review. The IRO cannot be affiliated with the MCO and must have a panel of medical experts qualified to review medical claims.

* IROs are also used by Medicare and state Medicaid programs in very specific ways. The same term—IRO—is often, but not always, also used in the commercial sector for any type of external utilization review. Medicare and Medicaid typically contract with only one IRO in a region, while most states require at least two IROs for external reviews of appeals in the commercial sector. A Medicare/Medicaid IRO may also participate in external reviews in the commercial market, but not always.

Most states require that more than one IRO be available, and the state, not the MCO, determines which cases go to which IRO.

Premium Taxes

All states assess a surcharge on every premium dollar paid to MCOs. These taxes are used to fund the operations of the state regulatory agencies as well as other state general fund expenditures. In many states, premium taxes are the second largest source of state revenue after revenues from individual and business income taxes.

Federal Oversight and Regulation

Starting with the HMO Act in 1973 and ERISA in 1974, the federal government has assumed increasing oversight of managed care and MCOs in the United States. These laws typically work in coordination with, and sometimes take the place of, state laws and regulations. Conflicts between state and federal laws pose challenges for MCOs as well as for their individual and employer customers.

Federal regulation and oversight of MCOs are carried out by several agencies, including:

- The U.S. Department of Health and Human Services (DHHS) has primary responsibility for establishing health insurance and managed care rules and providing oversight of MCOs. DHHS also sets the regulatory standards for health information privacy, data security, and electronic healthcare transactions and code sets.
- The U.S. Department of Labor sets rules governing health coverage benefits provided by employers and unions. These rules are enforced under the federal ERISA law.
- The U.S. Department of the Treasury has the authority to enforce tax laws governing health coverage. The federal tax code has an important role in determining how individuals and employers purchase health coverage offered by MCOs, and in defining certain cost-sharing limits.
- The U.S. Department of Justice has responsibility for enforcing criminal laws and penalties against MCOs for violations of federal standards, such as the health information privacy laws and laws on fraud and abuse involving government programs, such as Medicare.

Although Congress has enacted an extensive set of laws and regulations governing managed care, five laws have had the most significant impact on MCOs:

- The HMO Act, which provided the first federal recognition of HMOs and set standards for managed care
- ERISA, which established uniform national rules for employer- and union-sponsored health coverage
- HIPAA, which includes health insurance market rules, health information privacy and data security protections, and standards for electronic healthcare transactions and code sets
- The ACA, which built on the standards in ERISA and HIPAA and enacted additional requirements applicable to health insurance markets
- The federal tax code, which provides tax preferences to encourage individuals and employers to purchase health coverage

Legislation does not operate in a vacuum, and new laws frequently involve issues addressed in other laws that existed prior to a new law's passage. In almost all cases, it is neither practical nor desirable to repeal an older law, so new legislation typically must amend each relevant existing law accordingly. Because of that, the HMO Act, HIPAA, and the ACA also amend the Public Health Service Act (PHSA), which was passed in 1941.

Health Maintenance Organization Act (1973)

The HMO Act established the first federal requirements for federally qualified HMOs and provided loans and other financial guarantees for HMO start-up costs. Prior to the HMO Act, MCOs were found in only a handful of states, such as California and the Pacific Northwest. Federally qualified HMOs were required to provide a specified package of basic and supplemental health services to enrollees, including inpatient and outpatient care, home health services, preventive care, laboratory services, and emergency care. The HMO Act also required HMOs to meet solvency standards, provide procedures for handling member grievances and appeals, and establish programs for QA. This impact of the HMO Act is discussed in more detail in Chapter 1.

Employee Retirement Income Security Act (1974)

ERISA was enacted by Congress to provide a uniform legal framework for health and pension benefits offered by employers and unions. Congress passed this law in response to the varied and sometimes conflicting standards for health and pension benefits that raised operational challenges for businesses with workforces in multiple states. ERISA generally preempts state laws affecting health benefits provided by employers and unions. However, ERISA does not cover all types of group health plans; for example, it does not cover group health benefits plans established or maintained by governmental entities (e.g., for state employees) or by church-based group health plans.

Employers and unions have two options for providing health coverage: They can fully insure the benefits by purchasing insurance from an MCO or other health insurer, or they can self-fund by assuming the risk for the benefits' cost by setting aside sufficient financial resources to pay claims. In the latter case, the employer or union may contract with an existing MCO or a free-standing third-party administrator to handle the various administrative functions of the health plan, such as processing benefit claims.

ERISA sets out a number of requirements for employer and union health plans that frequently mirror state rules governing MCOs and managed care. The ERISA standards include the following considerations:

- Consumer information disclosures: The health plan must provide enrollees with a summary plan description describing the coverage available under the plan and any limits or restrictions, the healthcare professionals and hospitals in the plan's network, procedures for grievances and appeals, and information on the financial structure of the plan (i.e., are the benefits insured or self-funded by the employer or union).
- Fiduciary standards: Health plans are required to appoint a fiduciary that is responsible for operating the health plan and maintaining solvency. The fiduciary must operate in the interest of plan enrollees and in accordance with the plan documents, such as the benefits coverage provided by the health plan. Fiduciaries are also prohibited from engaging in any self-dealing or other prohibited transactions. If the fiduciary breaches its duties to the health plan or enrollees, it may be subject to legal action by plan enrollees or the Department of Labor.
- Claims and appeals: ERISA requires health plans to establish procedures for enrollees to appeal denials of health coverage and places limits on how quickly reviews must be conducted by the MCO. Enrollees must be permitted to present evidence to the plan challenging the denial and to have their appeal reviewed by a plan representative with healthcare

expertise. Denials of health coverage based on medical necessity may be submitted to an IRO if the enrollee is dissatisfied with the result of the appeal to the health plan. If the claim dispute is not resolved by the health plan or after submission to the IRO, the enrollee may file a lawsuit against the plan in federal court to recover the amount of the healthcare benefit.

- Reporting: Health plans are generally required to file annual reports with the Departments of Labor and the Treasury describing the type of coverage provided, the means by which coverage is financed, and the number of enrollees in the plan.
- Continuation of coverage: A later amendment to ERISA, COBRA requires employer and union health plans to allow enrollees to continue coverage for a period of time after they leave employment. Spouses and dependent children may also be entitled to continuation coverage in certain instances. Premiums charged for continuation coverage may not exceed 102% of the cost originally paid by the individual and his or her employer under the employer or union health plan. The continuation coverage requirements apply to group plans sponsored by employers with 20 or more employees (as discussed elsewhere in this chapter, states typically establish continuation of coverage requirements for businesses with fewer than 20 employees). This provision is intended to help individuals preserve their health coverage options after they lose their employer- or union-sponsored health coverage.

Health Insurance Portability and Accountability Act (1996)

Congress enacted HIPAA* to provide a standard set of insurance market requirements for health insurers, including MCOs. HIPAA set out the first significant set of federal standards for managed care for individuals and coverage provided to employer and union health plans. Many of these standards had previously been enacted by states, but the specific state requirements varied. The federal law also established the first national requirements for health information privacy, data security, and electronic healthcare transactions and code sets.

Key provisions of HIPAA include the following:

- Definition of group size: HIPAA defined a small employer as a business with up to 50 employees and a large employer as a business with more than 50 employees.
- Guaranteed availability of coverage: HIPAA required MCOs to provide group health coverage to any small employer (or an employee of the small employer) that wants to purchase coverage but only if certain conditions were met, such as only a small lapse of time having passed between when prior coverage ended and when new coverage was applied for. The ACA subsequently extended this right to all employers regardless of group size and to all enrollees in the individual market.
- Guaranteed renewability of coverage: MCOs are required to renew group health coverage for any employer (or any employee of the employer) that wants to continue its health plan for another year unless the employer or employee fails to pay premiums or engages in fraud or the MCO is leaving the market in a state or discontinuing a particular type of coverage. The ACA extended this right to enrollees in the individual insurance market.
- Preexisting condition limits: Under HIPAA, MCOs were not permitted to impose preexisting condition limits on enrollees for group coverage sold to

* HIPAA is technically an amendment to ERISA and the PHSA.

employers and unions, except in very limited situations. The ACA eliminated all preexisting condition limits or exclusions.

- Discrimination based on health status: HIPAA prohibits employers and MCOs from denying coverage or charging more for coverage based on the health status of the individual. Health status includes the individual's medical condition, claims experience, medical history, disability, or genetic information. This requirement was extended by the ACA to enrollees in the individual insurance market.
- Special enrollment periods: Employer- and union-sponsored group health plans typically enroll individuals once each year during an open enrollment period. HIPAA gives individuals the rights to enroll in group coverage outside of the open enrollment period due to certain qualifying events or life events, such as the birth or adoption of a child, marriage, divorce, or a spouse losing coverage.
- Health information privacy and data security: HIPAA established standards for the protection of personally identifiable health information, including protections for the collection, use, and disclosure of such information by MCOs and providers. MCOs are restricted from using an individual's health information without the person's consent unless the use is for purposes of payment, provision of health care, QM, or certain types of healthcare operations. MCOs are also prohibited from using health information for certain marketing purposes, such as selling the addresses of their enrollees to other businesses. These requirements extend to the business associates of the MCO that may be collecting, disclosing, or using health information on behalf of the MCO.
- Electronic healthcare transactions and code sets: HIPAA developed requirements for the electronic sharing of information between providers and MCOs, such as the transmittal of claims and information concerning the individual's eligibility for coverage.
- Mental Health Parity Act and Mental Health Parity and Addiction Equity Act: These two amendments to HIPAA set out requirements to provide coverage for the treatment of behavioral health conditions and substance abuse disorders on the same basis as coverage provided for medical and surgical benefits. For example, MCOs cannot impose limits on the number of days of treatment for a behavioral health condition if they do not impose similar treatment limits for medical conditions. The parity requirements also extend to nonquantitative treatment limits, such as utilization review—for example, the process used by the MCO to determine the medical necessity of behavioral health treatments must not be more restrictive than the process used for reviewing medical and surgical benefits.
- Genetic Information Nondiscrimination Act: This amendment to HIPAA placed limits on the collection and sharing of genetic information, including family history, and prohibits use of genetic information in setting premium rates.
- Newborns and Mothers' Health Protection Act: This amendment to HIPAA requires MCOs to provide coverage for hospital stays of up to 48 hours after a vaginal delivery and 96 hours after a delivery by cesarean section.
- Women's Health and Cancer Rights Act: This amendment to HIPAA requires MCOs to provide coverage for reconstructive breast surgery after a mastectomy.

Patient Protection and Affordable Care Act

The ACA significantly amended the standards set out in ERISA and HIPAA and imposed changes on how coverage is offered by MCOs. The provisions of the ACA also affect, and in

many cases supersede, state laws governing managed care and MCOs. Key provisions of the ACA include the following:

- Definition of markets by size: The ACA originally defined a small employer as a business with up to 100 employees; however, Congress subsequently amended the law to retain the old definitions of a small employer, meaning up to 50 employees.
- Guaranteed availability and renewability of coverage, and limits on preexisting conditions: The ACA extended and broadened HIPAA's requirements for MCOs to make coverage available to nearly all individuals and companies. HIPAA's guaranteed renewability requirements were extended to enrollees in the individual market. Additionally, MCOs are prohibited from imposing any preexisting condition limits or exclusions for coverage in the individual or group markets.
- Nondiscrimination: MCOs are prohibited from varying the premiums paid by individuals—whether purchasing coverage in the individual market or provided through their employer—based on their health status (e.g., an individual's health condition, disability, or medical history). This provision expanded on the earlier HIPAA requirements applicable to coverage provided to employees.
- Rating restrictions: The ACA limits the variability in premiums that may be charged by an MCO for health coverage. Rates may vary only based on family composition, geographic region, age (but only within restricted limits), and whether the individual uses tobacco (however, to assess a tobacco use surcharge, the MCO must waive the extra cost if the individual participates in a tobacco cessation program).
- Consumer information: MCOs are required to provide any prospective purchasers and enrollees with a summary of benefits and coverage document that describes what is covered or excluded, any cost-sharing requirements, such as deductibles and coinsurance, and the amounts the individual may be expected to pay for certain types of medical services.
- Coverage for preventive benefits: MCOs must provide coverage for a specified list of preventive benefits, such as routine physical examinations, laboratory tests, immunizations, and contraceptive services for women. The enrollee cannot be charged for the preventive services—for example, routine physician office visit copayments are no longer permitted. The list of preventive benefits is maintained and periodically updated by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control, and the Health Resources and Services Administration.
- Coverage for children up to age 26: MCOs that offer family coverage must agree to continue coverage for children up to age 26.
- Coverage for emergency services: MCOs must provide coverage for emergency services for all enrollees and cannot require the individual to pay a higher level of cost sharing for emergency care provided by nonnetwork providers than the individual would pay if it was provided in-network. The MCO is also prohibited from imposing any precertification or authorization requirements for emergency care.
- Access to primary care: Individuals enrolled in MCOs that require enrollees to designate a PCP must allow the individual to designate any participating PCP who is accepting patients, and women are permitted to designate their OB/GYN as their PCP.
- EHBs: MCOs are required to provide an EHB package to all enrollees in individual and small employer group market coverage, including prescription drugs,

inpatient and outpatient services, mental health and substance use disorder coverage, and habilitative services. In addition, coverage offered to families must include pediatric dental and vision benefits. The EHB coverage must provide an actuarial value of at least 60% (i.e., the value of the health benefits provided to an average enrollee is at least 60% of the total in-network or allowed benefits cost). Some of the specifics of the required services are delegated to states who are to base them on the top three products in the market.

- No annual or lifetime benefit limits: MCOs are prohibited from imposing any annual or lifetime coverage limits on EHBs.
- Health insurance exchanges: The ACA established insurance exchanges (called marketplaces) in each state as a mechanism for individuals and small businesses to purchase coverage. The state may choose to run the exchange or may partner with the federal government in running the exchange; the federal government is responsible for the exchange if the state fails to do so. Coverage in the exchange is divided into four "metal levels" and one additional optional product design for young individuals:
  - Copper plans (at least 60% actuarial value)
  - Silver plans (at least 70% actuarial value)
  - Gold plans (at least 80% actuarial value)
  - Platinum plans (at least 90% actuarial value)
  - MCOs may also offer individuals younger than age 30 the option to purchase "catastrophic" coverage with a higher deductible (and therefore lower premiums and actuarial value).
- Premium tax credits: Individuals with lower family incomes are eligible for a tax credit to assist with the purchase of health coverage through an exchange. Additionally, certain small businesses may qualify for tax credits for exchange health coverage offered to their employees.
- Medical loss ratios (MLRs): MCOs offering insurance coverage are required to meet annual MLR standards. In general, the MLR is defined as the amount of the premium dollar that is spent by the MCO on healthcare claims and on activities to improve health care (for example, wellness programs). In each state, coverage sold to individuals and small employers must have an MLR of 80% or higher, and coverage sold to large employers (and to individuals in MA plans) must have an MLR of 85% or higher. If the MCO does not meet the MLR target in a particular state, the MCO must refund any excess to enrollees. For example, if an MCO has an MLR of 75% for coverage sold in the individual market in a state, the MCO must refund 5% of the premiums collected back to individuals. Managed Medicaid plans were initially not included, but the 2016 Medicaid and CHIP Managed Care Final Rule imposed an 85% MLR limit on managed Medicaid plans beginning 2017.
- Individual coverage mandate: Starting in 2014, almost all individuals were required to have minimum essential coverage (MEC), such as insurance coverage purchased in the individual market or an exchange, coverage from their employer, or coverage from Medicaid or Medicare. Individuals who do not maintain MEC for themselves and any family members are assessed a penalty. There were exceptions for low-income individuals and those with religious objections to maintaining insurance coverage. However, Congress amended this requirement in 2018, and beginning in 2019 individuals without MEC will not be penalized.

- Employer coverage mandate: Employers with 50 or more employees must provide coverage or pay a penalty. The employer-sponsored health coverage must be affordable (i.e., the cost cannot exceed 9.5% of the employee's household income) and provide minimum value (i.e., the coverage must provide an actuarial value of at least 60%). The employer penalty applies only if the employer has one or more full-time employees who receive a tax credit for purchasing coverage through an exchange.
- Health insurance fees: Starting in 2014, a new federal annual fee was assessed on MCOs and other health insurers. The total industry fee in 2014 was $8 billion, increasing to $11.3 billion in 2015 and 2016, and $13.9 billion in 2017. Each health insurer's share of the total industry fee is based on its respective share of the insurance market for insurance sold to individuals and employers and government programs (e.g., Medicare and Medicaid). For nonprofit insurers, only 50% of premiums are considered for purposes of assessing the fee, and nonprofit plans that receive 80% or more of their income based on covering low-income, elderly, and/or disable individuals are exempt from the fee. Congress suspended collection of the fee in 2017 and again for 2019.
- Drug and medical device manufacturer fees: Starting in 2012, fees are assessed on manufacturers of drugs and medical devices. The total fees for 2013–2014 were $2.8 billion. They increased to $4.1 billion by 2018, but then fall back down to $2.8 billion in 2019 and thereafter.
- High-value plan tax: Employers (or their insurer or MCO) that provide high-value coverage are to be assessed an excise tax of 40% of the cost of the plan that is above a benchmark set by statute ($10,200 for self-only coverage and $27,500 for family coverage). These cost benchmarks will be adjusted upward for inflation in later years. In addition, individuals in certain types of "high-risk" professions, such as public safety employees, are subject to higher benchmarks in determining if their health coverage is subject to the excise tax. Like the individual coverage mandate, this provision has been the subject of debate; unlike the individual mandate, it has not been repealed as of the time of publication. However, Congress did delay the implementation of the high-value tax until 2020, and then delayed it again to 2022.

Congress attempted, and failed, to repeal the ACA on a number of occasions, but it has changed some of its provisions. As discussed, the individual mandate penalty was repealed, the health insurer fee has been suspended for two separate years, the medical device fee was suspended for a 2-year period, and some ACA rules have been rolled back. By the time you read this, other provisions of the ACA may have been amended or even eliminated, so the reader should seek current sources of information as appropriate.

Federal Tax Code

The federal tax code provides incentives for individuals and employers to purchase health coverage. For example, the cost of health coverage is fully tax deductible to employers and to their employees. Enrollees purchasing coverage in the individual insurance market may deduct the cost of health insurance premiums and other medical costs to the extent these expenses exceed a certain percentage of the individual's adjusted gross income; self-employed individuals may be able to deduct the entire premium under certain circumstances. Finally, the ACA allows certain lower income individuals purchasing coverage through an exchange (and only through an exchange) to qualify for a tax subsidy.

The tax code also recognizes three types of tax-advantaged spending accounts: HRAs, HSAs, and health Flexible Spending Arrangements (FSAs). HRAs and health FSAs may be offered only in conjunction with employer- or union-sponsored health coverage.* HSAs may be used by individuals or by enrollees in employer- and union-sponsored health plans. With all of these accounts, the individual (and in some cases the employer) contributes money into the account on a fully tax-deductible basis; this money may then be used for qualified medical expenses.

Conflicts, Preemption, and the Role of the Courts

State and federal laws and regulations frequently address the same issues involving managed care and MCOs. For example, the states had long-standing insurance market rules that were duplicated—but in some cases addressed differently—by HIPAA and the ACA. While ERISA governs self-funded employer- and union-sponsored health benefits plans and is regulated at the federal level by the DOL, states are responsible for oversight of the MCOs that provide insured group health benefits plans, meaning the insurer or MCO is at risk, not the employer. Determining whether state or federal laws should prevail and resolving conflicts poses challenges for MCOs and for state and federal regulatory agencies.

Two general legal principles govern whether a state law is preempted by the federal requirements. First, state laws may be preempted only if they directly conflict with a specific federal requirement. HIPAA and the ACA are generally enforced by the Department of Health and Human Services through its authority under the PHSA. The PHSA preempts state laws that "prevent the application" of the federal law. More plainly stated, if the MCO is unable to follow both the state law and the federal law, the federal requirements prevail. For example, the HIPAA electronic transaction and code sets standards preempt any state laws that are, or were, intended to regulate the electronic exchange of information between healthcare providers and MCOs.

In another example, states typically require MCOs to cover certain medical conditions and/or healthcare providers. Because federal law generally does not include similar coverage mandates (other than the ACA requirements to cover preventive services and emergency care), MCOs must comply with the state coverage mandates, but only for insured coverage for which the MCO is at risk.

There are situations in which a federal law is structured such that states are never permitted to regulate the same set of issues. One of the most significant of these areas involves ERISA, which generally preempts any state attempt to regulate a self-funded employer- or union-sponsored health benefits plan. For example, states are not permitted to tell the employer that self-funds its benefits how quickly claims must be paid, because ERISA leaves such regulation to the Department of Labor. However, a state can—and frequently does—regulate an MCO that is insuring an employer plan. In other words, the state can tell an MCO that is the insurer of an employee benefits plan—but not an MCO that is administering a self-funded benefits plan—how quickly claims must be paid.

Resolution of these conflicts is frequently handled by the judicial system. State and federal courts are often asked by an MCO, or by enrollees, employers, or healthcare providers,

* This is no longer exactly accurate for HRAs following a rule change by DOL and Treasury made after the chapter was written, but it remains accurate for FSAs.

to determine whether state law is preempted by the federal requirements. One of the primary areas of conflict and federal lawsuits involves questions of whether ERISA or state law should prevail.

Courts are also frequently asked to interpret other state and federal laws governing MCOs and managed care. Significant litigation has arisen over implementing the ACA, with the federal courts ruling on the validity of various provisions of the law. The U.S. Supreme Court has determined that the ACA is a valid law. However, it also found that two provisions of the ACA—one requiring states to expand Medicaid coverage and another telling certain types of closely held corporations that have religious objections that they must provide contraceptive coverage—are void.

Role of Nongovernmental Organizations

MCOs are affected by a number of nongovernmental organizations,* including the following:

- Designated Standards Maintenance Organizations
- Accreditation Organizations
- IROs
- NAIC

Designated Standards Maintenance Organizations

Under HIPAA, DHHS is responsible for the development, maintenance, and modification of relevant electronic data interchange standards that must be used by covered entities. DHHS does so by delegating these tasks to six designated standards maintenance organizations (DSMOs).

The DSMOs do not function in a vacuum. An example is the American National Standards Institute's Accredited Standards Committee X12 (ANSI ASC X12) that updates and maintains the format requirements for electronic healthcare transactions related to the business interactions between healthcare providers and MCOs. ASC X12 is provided input from other standards setting organizations that are not themselves DSMOs; for example, the American Medical Association, which maintains the Current Procedural Technology, Fourth Revisions (CPT-4) procedure codes; and the Centers for Disease Control and Prevention, which maintains the versions of the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes used in the United States (ICD overall is maintained by the World Health Organization [WHO]). There are many more organizations that serve to provide standards to the DSMOs as well.

Accreditation Organizations

Health plan accreditation organizations also set standards that most plans follow. Accreditation standards apply to a wide variety of managed care operations, such as UR/UM, QA/QM, provider network credentialing, and policies and procedures for making medical necessity determinations. Unlike HIPAA transaction and code sets, being accredited is not mandatory for any MCO.

There are three recognized accreditation organizations in the United States. While they differ in their approach to accreditation, their standards are similar. Of these three

* Nongovernmental organizations are often referred to by the acronym "NGO," but its use is inconsistent. For example, NGO is used more often for organizations working in other countries than for organizations working within the United States. This practice explains why this chapter—like this entire book—that is otherwise stuffed with acronyms does not use the acronym NGO.

accreditation organizations, the first two account for nearly all health plan accreditations, while the third focuses more on ambulatory healthcare facilities and providers:

- National Committee on Quality Assurance (NCQA)
- URAC (only the acronym is used)
- Accreditation Association for Ambulatory Health Care

Accreditation may be voluntary, but most states accept accreditation as meeting the state's standards in the functional areas addressed by accreditation. CMS accepts accreditation as well for MCOs in the MA program. One specific standard is mandatory, however, for MA plans as well as for licensure in some states: Reporting the results of the Healthcare Effectiveness Data and Information Set that was developed and is maintained by NCQA.

Independent Review Organizations

State law and the ACA require claim disputes involving medical necessity determinations to be submitted for review by an IRO if an individual covered under a healthcare benefits plan wishes to appeal a coverage denial, including a denial following an internal re-review by the plan. The IRO provides a panel of medical experts who review claims. Both enrollees (or their healthcare providers) and the MCO are allowed to present additional information that may be needed to determine if the MCO must provide the coverage.

National Association of Insurance Commissioners

As the name indicates, the National Association of Insurance Commissioners is an association of chief state insurance and managed care regulators in the 50 states, District of Columbia, and U.S. territories. The NAIC provides the insurance regulatory agencies and their staffs with the opportunity to share information on developments involving MCOs and to discuss legal and regulatory challenges, such as implementation of the ACA.

The NAIC develops model insurance laws and regulations affecting managed care—such as the Utilization Review Model Act—which are usually adopted by the states. In addition, the NAIC is responsible for creating the statutory accounting and risk-based capital standards used by MCOs and other insurers in financial reporting to the agencies. The NAIC also provides the insurance regulatory agencies with opportunities to coordinate financial and market conduct reviews of MCOs that operate on a national basis.

Conclusion

States continue to exercise significant control over the operations of MCOs and the provision of managed care to individuals. These requirements concern almost every aspect of managed care, from the types of organizations that may be licensed as MCOs, to the products offered to enrollees, to the premium rates that may be charged for insured coverage.

An increasing number of federal laws regulate the operations of MCOs. These laws directly govern MCOs, define how managed care may be provided, and regulate the employers and unions that contract with MCOs to administer their benefits plans. The federal requirements affect almost all aspects of managed care and MCO operations, including standards for how insurance coverage must be provided to individuals and employers, provisions affecting health benefits and group health plans, tax preferences for individual and group health coverage, and protections for health information.

Glossary of Terms and Acronyms

Author/Editor's Note: These are working definitions of common, and a few less common, terms and acronyms in the health insurance and managed healthcare industry. In such a dynamic industry, it is not possible to list every term or acronym in use because new ones appear faster than Tribbles. Terms also become obsolete or fall out of use, especially in the case of governmental agencies and programs, though not as fast as the appearance of new terms. The federal government is also constantly creating new words and terms, even when perfectly good existing words will do, and they are exceptionally fond of creating acronyms.

The entries included here are operational not legal definitions, and the reader must look to appropriate laws and regulations when legal matters are at issue. Some definitions will also change when laws and regulations change. Finally, some definitions in this glossary may also be disputed by others in the industry, and the author is open to receiving suggestions or different points of view from any such nitpickers.

A

AAAASF See American Association for Accreditation of Ambulatory Surgery Facilities.

AAAHC See Accreditation Association for Ambulatory Health Care.

AAC See Actual Acquisition Cost.

AAHC See American Accreditation HealthCare Commission.

Abandonment Rate The percentage of calls where the caller hangs up before reaching a service representative due to lengthy average speed to answer times.

ABN See Advanced Beneficiary Notice of Non-coverage.

Abuse or Healthcare Abuse A term that is not as well defined as billing fraud, abuse typically occurs if an activity abuses the healthcare system; for example, using billing codes that are related to, but pay higher than, the service actually provided, or charging outrageous fees.

ACA See Patient Protection and Affordable Care Act.

Access Fee A fee charged by a PPO or HMO for access to its provider network, including its payment terms, by an employer or another payer. See also Rental PPO.

Access Standards See Network Adequacy Standards.

Accountable Care Organization (ACO) A term coined by CMS and MedPAC, and used in the ACA, to describe an organized group of physicians and usually including a hospital, that are supposed to coordinate the care for beneficiaries with high medical costs who are in traditional FFS Medicare. Those beneficiaries are not locked in or required to use the ACO. CMS assigns or attributes them to the ACO through statistical means. An overall target cost is calculated, and the ACO shares in savings if costs are less than the target; in a two-sided model, the ACO pays back a portion of what it was paid if costs exceed the target.

Accreditation A formal type of recognition issued by a qualified impartial organization based on the accredited organization meeting defined quality and performance criteria. For payers, this means accreditation by NCQA, URAC, or (less commonly) AAAHC. For hospitals, it most commonly means accreditation by The Joint Commission. For ambulatory facilities, it may mean accreditation by the AAAHC. Other agencies exist for different types of hospitals and other licensed medical facilities such as rehabilitation, osteopathy, and so forth; some are listed in this Glossary. See also Deeming.

Accreditation Association for Ambulatory Health Care (AAAHC) An accreditation agency that focuses on ambulatory facilities such as ASCs, endoscopy centers, dialysis centers and so forth. It is also one of three accreditation agencies certified by CMS to accredit MA plans, along with NCQA and URAC.

Accreditation Commission for Health Care (ACHC) An accreditation organization focusing on community services.

Accrete The process of adding new Medicare enrollees to a plan. See also Delete.

Accrual An accounting and balance sheet term referring to money that is to be used for expenses or will come as income but has not necessarily been paid or received. See also accrual accounting.

Accrual Accounting Use of accruals for purposes of counting assets and liabilities. It differs from cash accounting, which means cash-in-hand and is what you do when you balance your checking or debit account (assuming you balance your checking or debit account).

ACD See Automated Call Distributor.

ACGs See Ambulatory Care Groups.

ACHC See Accreditation Commission for Health Care.

ACO See Accountable Care Organization.

ACR See Adjusted Community Rate.

Actual Acquisition Cost (AAC) The actual cost a pharmacy or provider paid to acquire a drug or a device, as opposed to a published average cost or a retail price.

Actuarial Assumptions The assumptions that an actuary uses in calculating the expected costs and revenues of a healthcare plan. Examples include (but are not limited to) utilization rates, age and sex mix of enrollees, cost for medical services, provider pricing, and cost-sharing.

Actuarial Equivalent (1) In the ACA, an aggregate level of cost sharing. For example, a Silver Plan has the actuarial equivalent of 30% cost sharing, meaning the total of all deductibles, copayments, and coinsurance for an average member adds up to 30%. (2) Under Medicare Advantage, a health benefit plan that offers coverage similar to that provided by a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, specific cost-sharing requirements, or even specific benefits, but the expected average amount of cost-sharing by enrollees in the different plans will be the same.

Acuity How sick a person is; typically used most often in the context of multiple chronic illnesses, but it can also be used in the context of a single costly illness.

ADGs See Ambulatory Diagnostic Groups.

Adjudication The management, processing, and final disposition of claims by a payer or health insurance company.

Adjusted Average Per-Capita Cost (AAPCC) The average amount of money spent on health care in a given area or by a given population on a per-person basis.

Adjusted Community Rate (ACR) A form of premium rating that does not take health status into account and that is instead based on factors such as age and geographic location. The ACA requires individual and small group health insurance to use adjusted community rates, with age-related adjustments limited to a 3 to 1 difference.

Administrative Contract Services (ACS) See Administrative Services Only.

Administrative Services Only (ASO) A contract between an insurance company or health plan administrator and a self-funded plan in which the insurance company or administrator performs administrative services only and does not assume any risk. Services usually include claims processing and member services, but may include other services such as actuarial analysis and utilization review. Also referred to as ASC. See also ERISA.

Admitted Asset A financial asset of a health plan that can be converted to cash on short notice

according to SAP. See also Statutory Accounting Principles, Statutory Net Worth, Nonadmitted Asset, and Risk-Based Capital.

Advanced Beneficiary Notice of Non-coverage (ABN) A form designated by CMS for use by providers and suppliers for all situations where Medicare payment is expected to be denied.

Advanced Payment Model (APM) A part of the QPP under MACRA in which professionals are paid through an alternative payment model and not through the MIPS program.

Adverse Selection The problem of attracting members who are sicker than the general population.

Affordable Care Act (ACA) See Patient Protection and Affordable Care Act.

Age Band or Age-Banding Putting individuals into different age groups for purposes of premium rate adjustments, with younger individuals paying lower premiums than older ones; applicable primarily to the individual and small group insurance markets. Under the ACA, the maximum difference between the lowest and highest age-banded premiums is 3 to 1 as of the time of publication.

Agency for Healthcare Research and Quality (AHRQ) A federal agency charged with addressing a wide array of utilization and quality-related issues. It also once operated a huge National Guidelines Clearinghouse (NGC) for clinical guidelines, but it was shuttered in 2018 when funding was eliminated.

Agent A person who is authorized by an HMO or an insurer to act on its behalf to negotiate, sell, and service coverage contracts. May be self-employed, employed by an agency, or employed by a broker.

AHIP See America's Health Insurance Plans.

AHP See Association Health Plan.

AHRQ See Agency for Healthcare Research and Quality.

All Payer A system in which the government state or federal sets payment rates for defined health services, which all payers, public and private, must follow. Potentially applies to hospitals and/or physicians. Used in many European nations but not (so far) in the United States, with the exception of Maryland where it applies to hospitals only. Also referred to as all payer rates or all payer fee schedule.

Allowed Charge The maximum charge that a payer (such as Medicare, Medicaid, or a commercial health plan) will cover for a specific service, even if the amount billed is greater than the allowed charge.

ALOS See Length of Stay.

Alternative Medicine See Complementary and Alternative Medicine.

Ambulatory Care Group (ACG) A method of categorizing outpatient episodes that are based on resource use over time, modified by principal diagnosis, age, and sex. See also Ambulatory Diagnostic Group, Enhanced Ambulatory Patient Group, and Ambulatory Patient Classification.

Ambulatory Diagnostic Group (ADG) A method of categorizing outpatient episodes. See also Enhanced Ambulatory Care Groups and Ambulatory Patient Group.

Ambulatory Patient Classification (APC) A methodology used by CMS to pay facilities for ambulatory services. Like DRGs, APCs bundle various charges into a single payment. Unlike DRGs, they are based primarily on procedures, not diagnoses. They also differ from DRGs in that they can be added together, while DRGs are used in a hierarchy for purposes of calculating payment. APCs are an outgrowth of APGs.

Ambulatory Patient Group (APG) See Enhanced Ambulatory Patient Group (EAPG).

Ambulatory Surgical Category (ASC) A term used by Medicare in its Hospital Outpatient Prospective Payment System (HOPPS) program. It specifically refers to a payment term using CMS's methodology.

Ambulatory Surgical Center (ASC) A facility for ambulatory procedures. The term may be applied to several types of outpatient facilities, not all of which are actually surgical, such as dialysis facilities and endoscopy facilities.

American Accreditation HealthCare Commission (AAHC) A name once used by URAC, but now obsolete. See also URAC.

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) An accreditation organization for ambulatory surgical centers.

American National Standards Institute (ANSI) An organization that develops and

maintains standards for electronic data interchange. HIPAA mandates the use of ANSI X 12N standards for electronic transactions in the U.S. healthcare system.

America's Health Insurance Plans (AHIP) The primary trade organization of health insurers and managed care organizations. Its areas of focus include legislative and lobbying efforts, education, certification of training in managed healthcare operations, and representation of the health insurance industry to the public. Initially there were three groups, Group Health Association of America (GHAA), American Managed Care and Review Association (AMCRA), and Health Insurance Association of America (HIAA), that represented different types of health plan constituencies. GHAA and AMCRA merged to form the American Association of Health Plans (AAHP), which in turn merged with HIAA to form AHIP.

Ancillary Services Healthcare services that are ordered by a physician but provided by some other type of provider for example, diagnostic testing or physical therapy. Most ancillary services fall into one of two categories: Diagnostic and Therapeutic, but not when those services are provided as part of an inpatient stay or an ambulatory procedure in a facility. Medical transportation is also a type of ancillary service, but dissimilar to diagnostic or therapeutic services. Pharmacy is typically not considered to be an ancillary service.

Annual Limit An archaic term referring to the maximum amount of coverage that a health plan would provide in a year; for example, coverage ends when costs exceed $1 million in a year. Annual limits are prohibited under the ACA.

ANSI See American National Standards Institute.

Any Willing Provider (AWP) A state law that requires a payer to accept any provider willing to meet the terms and conditions in the payer's contract, regardless of whether the payer wants or needs that provider in its network. Considered to be a form of anti-managed care legislation.

APC See Ambulatory Patient Classification.

APG See Enhanced Ambulatory Patient Group.

APM See Advanced Payment Model.

Appeal A formal appeal by a member of a denial of coverage. It requires a response within a fixed time frame. Under the ACA, a member can appeal at least twice once for an internal review and once for an external review. It is not the same as a grievance.

ASA See Average Speed to Answer.

ASC See Ambulatory Surgical Center (facility term) or Ambulatory Surgical Category (payment term).

ASO See Administrative Services Only.

ASP See Average Sales Price.

Assignment of Benefits A form signed by a patient directing the insurer to pay a nonparticipating provider directly, rather than reimbursing the member. The member is still liable for whatever a nonparticipating provider bills versus what the plan pays. Health plans, especially Blue Cross and Blue Shield plans, long refused to directly pay nonparticipating providers because direct payment is a valuable reason to participate due to difficulties collecting from patients, including those who receive a check from the insurer. To counter this, providers successfully lobbied state legislatures in several states to require it.

Association Health Plan (AHP) An association made up of smaller businesses that group together for purposes of providing group health benefits to employees. This may be done by purchasing group health insurance in which all of the businesses in the association participate equally, or it may be done by creating a pool of employees sufficiently large so as to self-insure, thereby avoiding state benefits mandates, premium taxes, or ACA requirements. AHPs have a spotty track record. See also Multiple Employer Welfare Association or Multiple Employer Trust.

Attachment Point A reinsurance contract term that refers to the size that a claim must be before any reinsurance coverage applies. For example, an 80/20 reinsurance contract with an attachment point of $100,000 means that if any individual incurred claims adding up to more than $100,000 in the contract period (usually a year), reinsurance would pay a percentage of costs in excess of $100,000, up to whatever maximum coverage is in place.

Authorization In the context of managed care, the need to obtain health plan approval before certain types of healthcare services are covered. Most commonly used in "gatekeeper"-type HMOs in

which a PCP must authorize a referral to a specialist or else the HMO will not pay for the specialist visit. Sometimes referred to as preauthorization, prior authorization, or precertification, though concurrent and retrospective authorizations can also occur.

Auto-adjudication The complete processing of a claim without any manual intervention. May also be applied to claims processing following claims data entry called claims capture. Claims capture is not a trivial cost, so comparisons of auto-adjudication rates between payers must use a consistent definition.

Automated Call Distributor (ACD) A computerized system that automatically routes calls or contacts coming into a call center based on programmed distribution instructions.

Average Handle Time The length of time it takes a customer service representative to resolve or complete a call or contact from a member.

Average Sales Price (ASP) A method to determine the amount that Medicare or a payer will pay for drugs, particularly biological or injectable drugs, or in some cases a device. It is based on the average price for which the manufacturer sells the drug, not what is charged by whoever is administering it. Payment for administering the drug is usually the ASP plus 6%.

Average Speed to Answer (ASA) The average time it takes to answer a call, typically measured in seconds; it is commonly used in measuring the performance of a customer service representative.

Average Wholesale Price (AWP) Commonly used in pharmacy contracting, a price that is generally determined through reference to a common source or sources of information.

Avoidable Readmission The unplanned readmission of a patient to a hospital within 30 (or 60) days of discharge for the same medical problem or one related to the first admission, and that could have been prevented through intervention. For example, a patient with a chronic condition who does not receive office-based follow-up care from his or her doctor or does not comply with his or her medications and is then rehospitalized would be considered an avoidable readmission.

AWP See Average Wholesale Price or Any Willing Provider.

B

BAA See Business Associate Agreement.

Balance Billing The practice of a provider billing a patient for all charges not covered by the benefits plan. Managed care plans and service plans generally prohibit contracted providers from balance billing except for allowed copayments, coinsurance, and deductibles.

Balanced Budget Act of 1997 (Pub. Law 105-33) (BBA '97) A sweeping piece of legislation, part of which created the Medicare+Choice program (since replaced by Medicare Advantage) as well as demonstration MSAs.

BCBS Blue Cross Blue Shield.

BD/K See Bed Days per Thousand.

Bed Days per Thousand (BD/K) Also called bed days per thousand per year; a standard method of measuring inpatient utilization on an annualized basis. It is the number of hospital days that are used in a year for each 1000 covered lives. It may be applied to differing time periods such as a single day, month to date, and year to date.

Behavioral Shift A change in the behavior of an individual with health insurance or managed care coverage based on the design of the benefits. For example, higher cost sharing may reduce unnecessary visits to the emergency department for nonurgent care, and out-of-pocket cost-sharing differences are meant to encourage members to use lower-cost providers.

Benefit Buy Down Increasing employee cost sharing so as to reduce an employer's benefits costs. This term is most often used by actuaries, underwriters, and benefits consultants.

Benefit Design The exercise of designing a benefits package to effectively compete in the market by balancing the level of benefits and the costs. The two most important elements of benefits design are cost-sharing and contingent benefits. See also cost-sharing and contingent benefits.

Benefit Waiver A part of most case management programs under which a case manager can authorize coverage for something that is not normally a covered benefit so as to keep a member out of the hospital. For example, a plan may pay for a hospital bed in the home even though it does not cover

durable medical equipment if it allows a member to receive home care rather than inpatient care.

Benefits Continuation Being able to continue coverage after losing regular eligibility; for example, continuing health benefits under COBRA for 18 months after losing employment.

Biologics A type of specialty pharmacy drug that is biologic in nature; it is usually created by recombinant DNA and administered via injection. Biologics exist for the treatment of cancer, rheumatoid arthritis, anti-inflammatory diseases, and a host of other conditions. They are usually extremely expensive and are considered a type of specialty pharmacy. Most types of insulin also are biologics, but by convention they are not treated like other biologics from a benefits standpoint.

Biosimilar A generic biologic drug, or a biologic drug that is similar enough to another one that it may be used in its place.

Blank A state financial filing form. There are numerous specific types of blanks, sometimes called schedules, such as annual reports and surplus reports.

Book Rate A premium rate developed using the experience of all individuals or groups in a specific block or pool; also called a manual rate or a base rate. The book rate is used as the basis for calculating various market rates such as family rates, single rates, and so forth. See also Community Rating.

BPCI See Bundled Payments for Care Improvement.

BPO See Business Process Outsourcing.

Bridge See Doughnut Hole.

Bronze Level of Benefits or Bronze Plan As defined in the ACA, a qualified health benefits plan with the actuarial equivalent or average of 40% cost sharing, when accounting for deductibles, copayments, and coinsurance as applied to in-network services.

Bundled Payment An all-inclusive payment for all facility and professional services associated with an episode of care.

Bundled Payments for Care Improvement (BPCI) CMS's name for a set of bundled payment models involving hospitals and (sometimes) physicians and (sometimes) a form of VBP as well.

Business Associate Under the privacy provisions of HIPAA, a person or organization that, on behalf of a covered entity (health plan, healthcare clearinghouse, or healthcare provider) or organized healthcare arrangement, performs or assists in the performance of activities involving the use or disclosure of protected health information (PHI). A business associate is not an employee of the covered entity. See also Protected Health Information.

Business Associate Agreement (BAA) A contract between a covered entity under HIPAA and one of its business associates, requiring the business associate to comply with the privacy and security requirements for covered entities.

Business Process Outsourcing (BPO) A form of outsourcing to a third party that focuses on one or more administrative processes of a payer such as claims or enrollment. See also Outsourcing.

Buy Down See Benefits Buy Down.

C

"Cadillac" Plan A slang term for high-cost health plan that exceeds cost levels defined under the ACA and therefore subject to a type of excise tax called the High-Cost Plan Tax (HCPT). It was to have gone into effect in 2018, was delayed twice, and at the time of publication is scheduled to go into effect in 2022. Its ultimate fate is unknown.

Cafeteria Plan An informal term for a flexible benefits plan.

CAHPS See Consumer Assessment of Healthcare Providers and Systems.

Call Center See Contact Center.

CAM See Complementary and Alternative Medicine.

Capitated Risk Pool See Risk Pool (Capitation).

Capitation A set amount of money received or paid out; it is based on membership rather than on services delivered and usually is expressed in dollars per member per month (PMPM). The amount may vary based on such factors as age and sex of the enrolled member.

Captive or Captive Insurer A restricted insurance company that provides coverage only for subsidiaries of its parent company or companies, not to the marketplace at large for example, a national employer with a subsidiary providing long-term

care insurance benefits to its employees. Captives are not subject to the same degree of regulation as regular insurers, and are often based offshore and subject to minimal regulation. Captives often do not have adequate reserves, putting them at more risk of failure; however, this is typically offset by having reinsurance from a commercial reinsurer. See also Fronting Insurer.

CAQH A nonprofit alliance of health plans, networks, and trade associations, that seeks to foster industry collaboration on initiatives that would simplify healthcare administration, including credentialing of providers. Once called the Council for Affordable Quality Healthcare, it changed its name to CAHQ.

CARC See Claims Adjustment Reason Code.

Care Continuum Alliance The organization for disease management, formerly called the Disease Management Association of America.

Care Coordination and Transition Management (CCTM) See Transition Management.

Care Management A broad term that is sometimes used synonymously with utilization management. Also, an umbrella-like term that refers to the combination of utilization management, disease management, case management, condition management, and so forth. Sometimes referred to as CM, which can be confusing because CM also stands for Case Management.

Carve-out (1) In relation to payment terms, something that is carved out of the basic payment methodology; for example, the cost of implantable devices might be carved out of hospital or ambulatory case rates and charged for separately. (2) In relation to plan benefits, a set of benefits that are carved out and contracted for and/or managed separately; for example, mental health/substance abuse services may be separated from basic medical/surgical services.

Case Management (CM) Also sometimes called Large Case Management (LCM). A method of managing the provision and coverage of healthcare services to members with high-cost medical conditions. The goal is to coordinate the care so as to improve continuity and quality of care as well as lower costs. It is generally a dedicated function in the utilization management department. According to the Certification of Insurance Rehabilitation Specialists Commission, "Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes" and "occurs across a continuum of care, addressing ongoing individual needs" rather than being restricted to a single practice setting. When focused solely on high-cost inpatient cases, it may be referred to as large case management or catastrophic case management. The abbreviation CM is also sometimes used for Care Management, which is a broader term usually applied to UM.

Case Mix The mix of illness and severity of cases for a provider; the mix of cases in an inpatient setting, accounting for differences in potential or real cost and outcomes. Case mix adjustment refers to use of case mix to evaluate performance of a provider or project potential costs.

Cat Claim A slang term for a catastrophic claim, meaning a very high cost claim. See also Shock Claim.

CCIIO See Center for Consumer Information and Insurance Oversight.

CCIP See Chronic Care Improvement Program.

CCO Corporate compliance officer. See also Corporate Compliance.

CCP See Coordinated Care Plan.

CCTM See Transition Management.

CDH/CDHP See Consumer-Directed Health Plan.

Census Also called a Hospital Census. In the context of health care, the number of filled inpatient beds, in whole numbers or as a percentage of a hospital's capacity. Payers may use this term to refer to the number of members who are inpatients at one hospital, or to the number of hospitalized members overall.

Center for Consumer Information and Insurance Oversight (CCIIO) An agency within CMS, responsible for ensuring compliance with the ACA's market rules and medical loss ratio rules. It assists states in reviewing insurance rates; provides guidance and oversight for state-based insurance exchanges; and compiles and maintains data on insurance.

Center for Medicare and Medicaid Innovation (CMMI) See CMS Innovation Center.

Centers for Medicare & Medicaid Services (CMS) The federal agency within the Department of Health and Human Services responsible for Medicare and (with the states) Medicaid and the implementation of the ACA.

CER See Comparative Effective Research.

Certificate of Authority A license issued by a state to an HMO that meets regulatory requirements; this form of state licensure is required for HMOs and differs from the insurance licenses that health insurers are issued.

Certificate of Coverage See Evidence of Coverage.

Certificate of Need (CON) The requirement that a healthcare organization obtain permission from an oversight agency before making changes; it generally applies only to facilities or facility-based services, and varies on a state-to-state basis.

CHAMPUS See Civilian Health and Medical Program of the Uniformed Services.

CHAP See Community Health Accreditation Program.

Chargemaster The list of every charge that a hospital has can make on a pure fee-for-service basis. What a hospital is actually paid by a payer, Medicare, or Medicaid rarely matches the charges listed on the chargemaster. Even when payment is not directly based on the chargemaster, it generally forms the basis upon which hospital payments are negotiated or paid one way or another.

Charitable and Benevolent Health Insurance Plans A nonprofit type of health benefits plan. Early BCBS plans and some HMOs were considered Charitable and Benevolent Health Insurance Plans and therefore not subject to taxes, but that changed with the Tax Reform Act of 1986.

Chase and Pay/Pursue and Pay A term (with an interchangeable first word) used in COB that means making the primary payer pay the claim first before the secondary payer pays anything. Also called Pursue and Pay. The antonym is Pay and Chase/Pay and Pursue. See also Coordination of Benefits and Pay and Chase.

CHIP See State Children's Health Insurance Program.

Chronic Care Improvement Program (CCIP) A requirement of the MMA, part of an MA plan that identifies enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation and employs a mechanism for monitoring enrollees' participation; a form of a disease management program under MA.

Churning The practice of a provider seeing a patient more often than is medically necessary, primarily to increase revenue through delivery of an increased number of services. Churning may also apply to any performance-based payment system where there is a heavy emphasis on productivity (in other words, rewarding a provider for seeing a high volume of patients whether through FFS or through an appraisal system that pays a bonus for productivity).

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) The old name for the federal program providing healthcare coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel, and certain others. The program is now called TRICARE. See also Military Health System and TRICARE. There is a similarly-named program called the Civilian Health and Medical Program of the Department of Veteran's Affairs (VA) (CHAMPVA) that is distinct and not to be confused with the old CHAMPUs.

Claim A bill for services from a healthcare provider to the organization or person responsible for payment. Claims can be paper or electronic.

Claims Adjustment Reason Code (CARC) Standardized codes required under HIPAA that payers must use on the explanation of benefits (EOB) statements informing the member about what was covered, how much (if anything) the plan paid, and how much the member is responsible for paying.

Claims Capture The process of entering claims data into a claims processing system. Electronic claims without errors and containing all required data are captured quickly and at very little cost. Standardized paper claims such as the CMS-1450 and the CMS-1500 are usually scanned in via optical character recognition programs, with the data then manually reviewed and corrected as needed. Member-submitted claims may also be scanned in or may require manual key entry, all of which are very expensive.

Claims Clearinghouse A company that accepts claims or other transactions from providers, formats

them according to HIPAA-compliant standards, and electronically transmits them to the payer.

Claims Made Insurance or Reinsurance A common type of reinsurance, medical malpractice insurance, professional liability insurance, D&O E&O insurance, and other forms of professional liability insurance. "Claims made" means that the insurer has liability only when the event occurred, and the insurer was informed of the potential for liability while the insurance was in force. If informed after the policy has lapsed, the insurer has no liability. See also Claims Paid Insurance or Reinsurance, Occurrence Insurance or Reinsurance, and Directors and Officers Errors and Omissions Insurance.

Claims Paid Insurance or Reinsurance A policy that applies to claims paid in a specific time period (e.g., 1 year). The coverage is for any claims paid during the contract period. After the period of coverage has ended, there is no further coverage for costs even if they were incurred during the period when the reinsurance was in force, but claims were not actually paid by the benefits plan. Coverage may extend to claims incurred for a defined period before and/or after the policy period if such coverage is purchased ahead of time. Not to be confused with claims made reinsurance/insurance, in which notification of the potential for liability, not necessarily the payment of a claim, is sufficient to activate coverage.

Claims Repricing An activity in which a rental PPO receives claims submitted by the participating providers, reprices them using the PPO fee schedule, and then transmits the repriced claim to the payer or insurance company for final processing.

Clawback When the government takes back some of the money it paid out to an organization or an individual.

Clean Claim A claim that has no errors and contains all required data. This term can apply to either paper or electronic claims, but is increasingly being used only for electronic claims.

Closed Formulary See Formulary.

Closed Panel A managed care plan that contracts with physicians on an exclusive basis. Examples include staff and group model HMOs, or health systems that offer a commercial health plan that is staffed primarily by their employed physicians. Note that even closed-panel plans contract with private physicians for services that the group or staff physicians are not able to provide.

CMP See Competitive Medical Plan.

CMS See Centers for Medicare & Medicaid Services. Also stands for contract management system when used in the context of network management systems support.

CMS Innovation Center A branch of CMS created under the ACA and charged with identifying, testing, and ultimately spreading new ways of delivering and paying for care in Medicare and Medicaid. It was previously called the Center for Medicare and Medicaid Innovation (CMMI).

CMS-1450 A paper claim form used by hospitals and facilities, which was standardized by CMS. It replaced the UB-92 form. It does not apply to electronic claims. CMS discourages paper claims, but the intermediaries will accept it if submitted. The same name is used by commercial payers for institutional claims forms along with the Universal Billing Form 04 (UB-04).

CMS-1500 A claims form used by professionals to bill for their services. It was developed for Medicare, but is also used in the commercial sector. It does not apply to electronic claims. CMS no longer accepts paper claims, although most commercial health plans do. Once called the HCFA-1500.

CMS-Hierarchical Condition Categories System (CMS-HCC or simply HCC) A system based on the diagnosis codes used in inpatient and outpatient settings as well as physician settings of care. The codes are assigned to groups of diagnoses called condition categories. The condition categories are ranked in a hierarchy, such that a higher category trumps a lower category for a patient whose diagnoses map to both categories. Each category is assigned a value (risk adjustment factor) based on the statistical relationship between that category and the following year's claim costs, and is used to adjust payments to MA plans.

COA See Certificate of Authority.

COB See Coordination of Benefits.

COBRA See Consolidated Omnibus Budget Reconciliation Act.

Code Sets Sets of codes used by providers to bill for services. HIPAA created a requirement for certain codes to be used for electronic transactions.

These required code sets are ICD-10-CM and ICD-10-PCS, CPT-4, NDC, HCPCS, and the Code on Dental Procedures and Nomenclature.

Coinsurance A cost-sharing provision in a member's coverage that is based on a percentage of covered charges paid by the plan. Coinsurance may vary in some plans depending on whether a service was received from an in-network versus out-of-network provider (e.g., 80% for in-network care, 60% for out-of-network care), but are always based on what the plan covers, not necessarily what the provider charges. Any additional costs are paid by the member out of pocket. See also copayment.

Commercial Health Plan Health insurance or HMO coverage for subscribers who are not covered by virtue of a governmental program such as Medicare, Medicaid, or SCHIP. May be an insured or a self-funded plan.

Commission The money paid to a sales representative, broker, or other type of sales agent for selling the health plan. May be a flat amount of money or a percentage of the premium.

Community Rating A form of premium rating required by the ACA for all individual and small group coverage. With community rating, the HMO or insurer obtains the same amount of money per member for all members in the appropriate coverage group, adjusted for cost-sharing. Community rating is usually calculated as adjusted community rating. See also Adjusted Community Rating and Experience Rating.

Comparative Effective Research (CER) The use of scientific studies to determine how effective one type of treatment or procedure is compared to another. Used to determine some evidenced-based medical guidelines.

Complementary and Alternative Medicine (CAM) Treatment modalities other than traditional allopathic medicine. Examples include acupuncture, chiropractic medicine, homeopathy, and various forms of "natural healing."

Compliance See Corporate Compliance.

Compounding Pharmacy A pharmacy that combines different existing drugs or solutions for administration for example, mixing small amounts of a chemotherapeutic drug with a solution for injection into an organ, or mixing multiple drugs into a single topical cream.

Comprehensive Primary Care Initiative (CPC) A CMS pilot program providing additional support to hundreds of PCP practices in the United States with a goal of improving primary care delivery, quality of care, and reducing spending. It has not been completely successful because cost savings did not offset the cost of the program. It may yet be found valuable, however.

Compression See Premium Cost Compression.

Computer Telephony Integration (CTI) In a payer's call center or contact center, the use of information input by a member at the beginning of a call to access relevant data in the transaction system, route the call to the most appropriate customer service representative (CSR), and provide decision support to the CSR.

Computerized Physician Order Entry (CPOE) A system in which a physician enters medical orders into an electronic medical record or transactional system such as a drug dispensing program. It is supposed to lower the error rate caused by illegible handwriting, but one can also click on the wrong drug from a drop-down menu. CPOE systems may also be partially or completely automated for certain things, such as routine or standing orders for a patient admitted to the ICU.

Community Health Accreditation Program (CHAP) An accreditation organization focused on community services such as home health, hospice, and similar programs.

CON See Certificate of Need.

Concurrent Review Utilization management that takes place during the provision of services. This term is mostly used with inpatient hospital stays, but also may apply to certain extended types of treatment such as long-term rehabilitation or physical therapy.

Condition Management A term that may be used interchangeably with disease management, or to refer to the management of those patients with multiple chronic conditions, meaning a sort of multi-disease management. See also Disease Management.

Consolidated Omnibus Budget Reconciliation Act (Pub. Law 99–272) (COBRA) Legislation that, among other things, allows for a limited continuation of healthcare coverage for people who lose their eligibility for coverage through an employer group's

medical plan. See also Benefits Continuation and Conversion.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) A rating system begun by the federal government for use in Medicare and Medicaid managed care plans, but which is now also used by commercial health plans. It is maintained by the AHRQ and participation is required as part of the NCQA accreditation process. Its initial focus was on managed healthcare plans, but was expanded to ambulatory providers, hospitals, medical groups, the Medicare prescription drug program, Medicaid, and others.

Consumer-Directed Health Plan (CDH/CDHP) A type of benefit design that combines a qualified HDHP with a pretax fund such as a health reimbursement account (HRA) or a health savings account (HSA). The HRA or HSA is used to pay for qualified services on a first-dollar basis, but is not large enough to cover the entire deductible, the so-called doughnut hole. CDHPs are also supposed to provide information such as cost data and decision-support tools to consumers to promote greater involvement on the part of the consumer in making healthcare choices, but sometimes are simply a plan design that has low premiums because of high cost-sharing.

Consumer Operated and Oriented Plan (CO-OP) Program Under the ACA, a new type of consumer-operated, nonprofit payer organization offering coverage through a state health insurance exchange. Most, but not all, failed. Not to be confused with Co-op, referring to a healthcare cooperative, which is similar but not the same; see also Healthcare Cooperative.

Consumer Portal See Portal.

Contact Center The place within a payer that supports inbound inquiries across a broad array of media (most frequently, inbound telephone calls), blended with outbound contact and outreach transactions.

Contingent Benefits A term used for medical goods or services that may or may not be covered depending on circumstances such as meeting criteria in evidence-based medical guidelines.

Continuation Benefits See Benefits Continuation.

Contract Management System (CMS) A computer program or database management system that keeps track of the various provider contracts and their terms. A CMS may also sometimes be used to track employer group master contracts and benefits terms, but that system is usually separate from the provider system. Not to be confused with the Centers for Medicare and Medicaid that is also called CMS.

Contract Year The 12-month period that a contract for services is in force. It is not necessarily tied to a calendar year.

Contributory Plan A group health plan in which the employees must contribute a certain amount toward the premium cost, with the employer paying the rest.

Convenient (or Convenience) Care Clinic (CCC) See Retail Clinic.

Conversion The conversion of a member covered under a group master contract to coverage under an individual contract. This option is offered to subscribers who lose their group coverage (e.g., through job loss, death of a working spouse) and who are ineligible for coverage under another group contract. Rarely used anymore, but it does exist.

Conversion Factor The dollar amount that is used in RBRVS FFS and some other payment methodologies to change payment amounts periodically; for example, multiplying the number of RVUs times the Conversion Factor equals the payment amount in dollars. Allows payment rates to change without having to change the method used to calculated them. **May also be called a Multiplier.**

Co-op See Healthcare Cooperative.

Coordinated Care Plan (CCP) Network-based Medicare Advantage plans that include HMOs, PPOs (both regional and local), IDSs that operate like HMOs, and HMOs with point-of-service products. CCPs can require enrollees to use a network of providers for coverage of Medicare services.

Coordination of Benefits (COB) A process to prevent double payment for services when an individual has coverage from two or more sources. For example, one parent may have Blue Cross Blue Shield insurance through work, and the other parent may have elected to join an HMO through her or his place of employment; if both parents elected family coverage, then their child or children would be covered under both plans. COB determines which organization has primary responsibility for

payment and which organization has secondary responsibility for payment. The respective primary and secondary payment obligations of the two carriers are determined by the order of benefits determination (OOBD) rules contained in an NAIC Model COB Regulation, as interpreted and adopted by the various states. See also Other Party Liability. Medicare has its own COB policy referred to as Medicare Secondary Payer (MSP) when Medicare is secondary.

Copayment A fixed amount, such as $25, that a member must pay out of pocket for a medical service or prescription; it almost always it applies only to in-network care or drugs on the formulary. Also called co-payment. See also Coinsurance.

Corporate Compliance The function in a health plan or provider charged with ensuring compliance with state and federal rules and regulations, of which there are many. Regulations also require written policies and procedures, and the existence of a corporate compliance officer.

Corporate Practice of Medicine (CPM) Law A state law that prohibits a corporation (other than a professional corporation, or PC) from practicing medicine or employing a physician to provide professional medical services. Some states with CPM laws allow certain corporations such as hospitals or HMOs to employ physicians, however.

Cost Sharing Any form of coverage in which the member has an out-of-pocket cost for healthcare services. Usual forms of cost sharing include deductibles, coinsurance, and copayments.

Cost-Sharing Reduction (CSR) A form of financial support in the ACA that lowers the amount of cost-sharing paid out-of-pocket by qualified individuals or families that purchased coverage through a health insurance exchange. To receive this extra savings, eligible individuals or families must be enrolled in a Silver plan.

Cost Shifting A situation in which a provider shifts at least some of the cost of providing services to individuals covered by a payer that does not cover the actual cost of care, such as Medicaid, by raising prices to other payers such as commercial health plans.

Council for Affordable Quality Healthcare See CAHQ.

Coverage Gap See Doughnut Hole.

Covered Entity A person or organization that must meet the HIPAA standards for transactions, code sets, privacy, and security; defined as a provider (professional or facility), a health plan, or a claims clearinghouse; and indirectly may include Business Associates to a limited degree.

CPC See Comprehensive Primary Care Initiative.

CPM Law See Corporate Practice of Medicine Law.

CPOE See Computerized Physician Order Entry.

CPT-4 See Current Procedural Terminology, Fourth Edition.

Credentialing Obtaining and reviewing the documentation of professional providers. Such documentation includes licensure, certifications, insurance, evidence of malpractice insurance, malpractice history, and so forth. It generally includes both reviewing information provided by the provider and verifying that the information is correct and complete. For payers, this applies primarily to licensed medical professionals; payers do not directly credential facilities beyond determining that the facility has a valid and unrestricted state license(s), insurance, and participates with Medicare.

Credentialing Verification Organization (CVO) An independent organization that performs primary verification of a professional provider's credentials. The managed care organization may then rely on that verification rather than requiring the provider to provide credentials independently. This lowers the cost and "hassle" for credentialing. NCQA has issued certification standards for CVOs.

Credibility An insurance term that refers to how much weight is given to a group's prior experience for purposes of calculating premiums under experience rating. The larger the group and the longer the history, the more credibility is given to past experience.

Creditable Coverage Healthcare benefits coverage from any source that meets the ACA's or ERISA's minimum standards to be creditable. In the context of a special enrollment period, it also refers to proof that an individual had creditable coverage for 60 days or less prior to obtaining new coverage or a coverage extension. See also Special Enrollment Period.

Critical Paths Defined pathways of clinical care that provide for the greatest efficiency of care

at the greatest quality. Critical paths are also an ever-changing activity as science and medicine evolve. This term is being replaced through common usage with the term "clinical guidelines."

CRM See Customer Relationship Management.

C-SNP An MA Special Needs Plan for Medicare or Dual beneficiaries with one or more severe or disabling chronic conditions. A type of Part C plan.

CSR See either Customer Service Representative, or Cost-Sharing Reduction as appropriate.

CTI See Computer Telephony Integration.

Current Procedural Terminology, Fourth Edition (CPT-4) A set of five-digit codes used for identifying medical procedures. It is frequently used for billing by professionals and is maintained by the American Medical Association. See also Healthcare Common Procedural Coding System.

Custodial Care Care provided to an individual that consists primarily of assistance with the basic activities of living. It may be medical or nonmedical, but the care is not meant to be curative or to serve as a form of medical treatment; it is often lifelong. Custodial care is not a covered benefit in any form of group health insurance, HMO, or Medicare. Only long-term care insurance policies (which are not health plans) or, for the indigent, Medicaid, provides any coverage for custodial care.

Customer Relationship Management (CRM) Originally, all of the processes and information systems used by an organization in regard to its interactions with its customers, such as telephone calling systems and customer databases. Today this term is used more broadly to include the use of the same processes and technology applied to any external constituency, such as a payer's nonroutine interactions with its providers.

Customer Service Representative (CSR) An individual in the member services function who has direct communications with members. There are usually different levels of CSRs consistent with these individuals' different levels of experience, training, and authority. See also Member Services.

Customer Services See Member Services.

CVO See Credentialing Verification Organization.

CWW Clinic Without Walls. See Group Practice Without Walls.

D

D&O Directors and Officers. Referring to the members of a company's board of directors and its officers.

D&O E&O Directors and Officers Errors and Omissions insurance – See Errors and Omissions insurance.

Data Transparency The practice in which a payer or governmental agency makes data about healthcare costs, pricing, and/or quality available to consumers, usually via the Internet.

The Databank The federal data repository that includes both the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

Date of Service The date on which medical services were rendered. It is usually different from the date a claim is submitted.

DAW See Dispense as Written.

Days per Thousand See Bed Days per Thousand.

DCG See Diagnostic Care Group.

Death Spiral An insurance term that refers to a downward spiral of high premium rates and adverse selection. A payer, or sometimes a covered group, ends up having continuously and rapidly rising premium rates such that the only members who stay with the plan are those whose medical costs are so high that they far exceed any possible premiums. The losses from underwriting mount faster than the premiums can ever cover, and the account eventually terminates coverage, leaving the carrier in a permanent loss position and possibly resulting in the insurer's bankruptcy.

Deductible The amount of out-of-pocket costs that must be paid before any portion is also paid by the health plan. The amount often differs between in-network non-emergency services and out-of-network, if there is out-of-network coverage. It also usually differs for pharmacy coverage and all other types of coverage.

Deeming The practice in which an organization that is accredited by the appropriate accreditation agency as meeting defined requirements is deemed to comply with regulatory requirements. For payers, accreditation by NCQA, URAC, or (less commonly) AAAHC is deemed by CMS as meeting at

least some requirements for participation in Medicare Advantage. Many states also deem accredited plans as complying with certain requirements of licensure. Accreditation by The Joint Commission for hospitals and ambulatory facilities, and accreditation by AAAHC for ambulatory facilities, are usually deemed as complying with certain state and Medicare requirements.

Defined Benefit A type of benefits plan in which an insurer, HMO, or employer provides a benefit that is the same regardless of the cost to provide that benefit. Under the ACA, only defined benefits plans can be considered as creditable health plans.

Defined Contribution A limited benefits plan in which coverage is defined as a fixed amount of money, regardless of cost; for example, $400.00 per day if hospitalized. Generally speaking, defined contribution plans do not meet the ACA's requirement for creditable coverage. The term also applies to benefits plans to which an employer contributes a fixed amount of money and the beneficiary uses it as appropriate; for example, a Flexible Spending Account.

Delete The term used by CMS for the process of removing Medicare enrollees from a plan. See also Accrete.

Demand Management Services or support that a payer provides to members in an effort to lower the demand for acute care services. It includes self-help tools, nurse advice lines, and preventive services.

Dental Content Committee of the American Dental Association A designated standards maintenance organization under HIPAA that focuses on coding standards for dental procedures.

Dental Health Maintenance Organization (DHMO) An HMO organized strictly to provide dental benefits.

Department of Health and Human Services (DHHS) The U.S. Cabinet-level federal agency that oversees many healthcare-related programs, including the CMS, which is responsible for Medicare and Medicaid (in conjunction with individual states), as well as HIPAA, the ACA, and other related federal legislation.

Department of Labor (DOL) The U.S. Cabinet-level federal agency that regulates, among many other things, coverage offered to employees when employers retain the insurance risk through self-funding pursuant to ERISA, either on a standalone basis or through a multiple employer welfare arrangement. Certain ERISA requirements are also applicable to insured plans and, therefore, are regulated by the DOL as well.

Dependent A member who is covered by virtue of a family or other legal dependency relationship with the member who has the health plan coverage. For example, one person may have health insurance or an HMO through work, and that individual's spouse and children, the dependents, may also therefore be eligible for coverage under the same contract. Children may be covered as dependents up to age 26.

Designated Standards Maintenance Organization (DSMO) An organization designated in HIPAA that is charged with making recommendations to DHHS regarding updates to existing standards as well as the addition of new standards to the transactions and code sets.

Det Norske Veritas A hospital accreditation organization. Also called Stiftelsen Det Norske Veritas.

DFRR See Disclosure of Financial Relationships Report.

DHHS See the Department of Health and Human Services.

DHMO See Dental Health Maintenance Organization.

Diagnosis-Related Groups (DRGs) The initial version of the statistical system of classifying any inpatient stay into groups for purposes of payment. DRGs may be primary or secondary, and outlier classifications also exist. This is the form of payment that the CMS used to pay hospitals for Medicare recipients. It was also used by a few states for all payers and by many private health plans for contracting purposes. CMS replaced DRGs with MS-DRGs in 2008–2009, and most commercial plans that used DRGs have followed suit. See also MS-DRG.

Diagnostic Care Group (DCG) A methodology commissioned by the CMS to look at how to adjust prospective payments to health plans based on retrospective severity. It was replaced by the CMS-Hierarchical Condition Categories (HCC). See also Hierarchical Condition Categories.

Direct Access See Open Access.

Direct Contract Model A managed care health plan that primarily contracts directly with private practice physicians in the community, rather than through an intermediary such as an independent practice association or a medical group. A common type of model in open-panel HMOs.

Direct Contracting (1) Contracting directly with private practice physicians for specialty services not available through a contracted group or an IPA. (2) A system in which a provider or integrated healthcare delivery system contracts directly with an employer rather than using an insurance company or managed care organization. This option occasionally works when the employer is large enough and employees are mostly located in one geographic region. This approach often does not last for long because it almost always ends up being costlier than working through an existing health plan, though there are exceptions.

Direct-Pay Subscriber An individual subscriber to a health plan who is not covered under a group policy, but rather pays the health plan directly. This term is usually not used to describe Medicare or Medicaid subscribers because part or all of their premiums are paid via a governmental agency.

Directors and Officers Errors and Omissions (D&O E&O) insurance See Errors and Omissions insurance.

Discharge Planning That part of utilization management that is concerned with arranging for care or medical needs to facilitate discharge from the hospital.

Disclosure of Financial Relationships Report (DFRR) A mandatory hospital disclosure form applicable to Medicare. It was created by CMS to report any financial relationships between hospitals and physicians, and to measure compliance with physician self-referral statutes and regulations.

Disease Management (DM) The process of more closely managing members with one or more specific diseases. DM differs from large case management (LCM or CM) in that it goes well beyond a given case in a hospital or an acute exacerbation of a condition, and it typically focuses on a defined set of specific conditions such as diabetes, cardiac disease, and so forth. Disease management encompasses all settings of care, and it places a heavy emphasis on prevention and maintenance. See also Condition Management.

Disenrollment The process of termination of coverage. Voluntary termination would include a member quitting because he or she simply wants out. Involuntary termination would include a person leaving the plan because he or she takes a new job or loses eligibility for coverage. A rare and serious form of involuntary disenrollment is when the plan terminates a member's coverage against the member's will. This step is usually allowed (under state and federal laws) only for gross offenses such as fraud, abuse, or nonpayment of premiums or copayments.

Disenrollment Period As used for MA plans and/or PDPs, it is the period between January 1 and February 14 during which a Medicare beneficiary that enrolled in an MA plan and/or PDP can opt out and return to original Medicare. After that they are "locked in" to their coverage. See also Lock In Period.

Dispense as Written (DAW) The written instruction from a physician to a pharmacist to dispense a brand-name pharmaceutical rather than a generic substitution.

Dispensing Fee The fee paid to a pharmacy for that part of the cost of a prescription that is not the ingredient cost. Usually a flat dollar amount, not tied to the cost of the drug.

Disproportionate Share Hospital (DSH) Payment An amount added to payments by Medicare and Medicaid to help defray the costs of uncompensated care or for having a disproportionately high percentage of low income or indigent patients. It differs for each hospital and state and is based on a complex formula. DSH payments were significantly reduced as of 2014 under the ACA because of coverage expansions through subsidized commercial health insurance and the Medicaid expansion; hospitals in states that have not expanded Medicaid took a hit because they no longer receive DSH payments but still provide uncompensated care.

Distribution Channel or Distribution The various ways that a payer sells its products for example, brokers, consultants, employed sales force, and electronic sales portals.

DM See Disease Management.

DME See Durable Medical Equipment.

DOL See Department of Labor.

Doughnut Hole Also called a Coverage Gap, it is the difference between when first-dollar coverage stops and insurance begins; also may be referred to as a bridge. This term may be applied in a CDHP plan to the gap between the health reimbursement account/health savings account and the point at which the high-deductible insurance plan starts to cover costs. A doughnut hole also existed in the basic Medicare Part D drug benefit passed under the MMA, but under the ACA it was mostly phased out by 2020.

Downstream Risk When a capitated provider subcapitates another provider to assume a portion of the capitated provider's risk. For example, a large medical group is paid capitation for all professional services, and in turn subcapitates (capitates) a specialty medical group for all services related to that specialty.

DRGs See Diagnosis-Related Groups.

Drive Time The average amount of time it takes for a member to get to a provider. It is often used as a measure of network accessibility.

Drug Utilization Review (DUR) Utilization management applied to the pharmaceutical benefit. It relies mostly on prospective review but does use some concurrent review as well.

DSH See Disproportionate Share Hospital Payments.

DSMO See Designated Standards Maintenance Organization.

DSM-V (or DSM-5) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. The manual used to provide a diagnostic coding system for mental and substance abuse disorders. See also ICD-10.

D-SNP Dual-eligible Special Needs Plan for beneficiaries who are eligible for both Medicare and Medicaid ("dual eligibles" or "duals"). A type of Part C plan.

Dual Choice An archaic term, sometimes also referred to as Section 1310 or mandating. That portion of the original HMO Act that required any employer that met certain criteria 25 or more employees who reside in an HMO's service area, pays minimum wage, and offers health coverage to offer a federally qualified HMO as well. This provision of the HMO Act "sunsetted" or expired in 1995.

Dual Eligibles or Duals Individuals who are entitled to both Medicare and Medicaid coverage. Sometimes referred to as "Medi-Medi's."

Dual Option This once referred to offering both an HMO and a traditional insurance plan by one carrier. It now refers to (1) offering two different health plans, regardless of type, or (2) to a POS plan that has only in-network and out-of-network benefits, meaning there is no associated PPO as a middle option (which is often called a Triple Option).

Duplicate Claims A situation in which the same claim is submitted more than once, usually because payment has not been received quickly. It can lead to duplicate payments and incorrect data in the claims file, and to the need to recover overpayments form providers; at the very least it can clog up the claims system.

DUR See Drug Utilization Review.

Durable Medical Equipment (DME) Medical equipment that is not disposable (i.e., is used repeatedly) and is related to care for a medical condition. Examples include wheelchairs, insulin pumps, and orthotics.

E

E&O Errors and Omissions. See Errors and Omissions Liability Insurance.

EAP See Employee Assistance Program.

EAPGs See Enhanced Ambulatory Patient Groups.

Early and Periodic Screening, Diagnostic, and Testing (EPSDT) A defined set of screening benefits provided to children covered under Medicaid.

Earned Premium That portion of the premium attributable to coverage for a time period that has already passed, and is booked as an asset. That portion of a premium that will apply to coverage in the future is considered an unearned premium until the time period that the premium is meant to cover has passed, and until then it is booked as a liability. Applies only to prepayment of premiums for a defined period of time such as a month or a quarter; which is the usual form of premium payment.

e-Business See e-Commerce.

e-Commerce The use of electronic communications to conduct business; also called e-business.

ED See Emergency Department.

EDI See Electronic Data Interchange.

Edit In the context of health insurance and managed care, it is a term used in claims processing. See also Suspend.

EDS See Encounter Data System.

Effective Date The day that health plan coverage goes into effect or is modified.

EFT See Electronic Funds Transfer.

EHR See Electronic Health Record.

Electronic Data Interchange (EDI) The exchange of data through electronic means rather than by using paper or the telephone. Prior to the rise of the Internet, EDI was applied primarily to direct electronic communications via proprietary means. EDI now encompasses electronic data exchange via both proprietary channels as well as the Internet.

Electronic Funds Transfer (EFT) Getting paid by electronic transfer of funds directly to one's bank instead of receiving a paper check.

Electronic Health Record (EHR) An expansive type of electronic record encompassing more than the care provided by a single provider or entity to a single patient.

Electronic Medical Record (EMR) An electronic version of the type of health record that a physician or a hospital keeps on a single patient, though it could apply to any patient-specific clinical record.

Electronic Remittance Advice (ERA) A communication used in conjunction with EFT payments.

Eligibility The condition in which an individual meets the criteria for coverage under a plan. It is also used to determine when an individual is no longer eligible for coverage (e.g., a dependent child reaches a certain age and can no longer receive coverage under his or her parent's health plan). The same term may be used with groups.

Emergency See Emergency Medical Condition.

Emergency Department (ED) The location or department in a hospital or other institutional facility that is focused on caring for acutely ill or injured patients. In earlier times, this was often a room or set of rooms; hence the older designation emergency room (ER) that remains in common use.

Emergency Medical Treatment and Active Labor Act of 1986 (Pub. Law No. 99-272) (EMTALA) "Antidumping" legislation that dictates all patients presenting to any hospital emergency department must have a medical screening exam performed by qualified personnel, usually the emergency physician. The medical screening exam cannot be delayed for insurance reasons, either to obtain insurance information or to obtain preauthorization for examination. This legislation also provides a definition of emergency medical condition that is used both for EMTLA purposes and, using a prudent layperson standard, as part of the ACA.

Employee Assistance Program (EAP) A program that a company puts into effect for its employees to provide them with help in dealing with personal problems such as alcohol or drug abuse, mental health issues, and stress issues.

Employee Retirement Income Security Act (Pub. Law 93-406) (ERISA) Federal legislation that allows self-funded plans to avoid paying premium taxes, complying with state-mandated benefits, or otherwise complying with most state laws and regulations that apply to health insurance. Another example is a provision requiring plans and insurance companies to provide an explanation of benefits (EOB) statement to a member or covered insured in the event of a denial of a claim, explaining why the claim was denied and informing the individual of his or her rights of appeal; this aspect was significantly strengthened under the ACA. Numerous other provisions in ERISA are very important for a managed care organization to know.

Employer Coverage Mandate A provision of the ACA that requires employers with 50 or more full-time employees to offer affordable coverage or face a financial penalty, though exceptions exist.

EMR See Electronic Medical Record.

EMTALA See Emergency Medical Treatment and Active Labor Act.

Encounter An outpatient or ambulatory visit by a member to a provider. This term applies primarily to physician office visits, but may encompass other types of contacts as well. In FFS plans, an encounter also generates a claim. In capitated plans, the encounter is still the visit, and a claim may even be generated, but it does not result in a claims payment.

Encounter Data System (EDS) A data file system CMS began to use as the basis for Medicare

Advantage member risk scores, replacing the older Risk Adjustment Processing System (RAPS) data file system.

End-Stage Renal Disease (ESRD) A clinical condition involving failure of the kidneys. Medicare treats beneficiaries with ESRD differently than other individuals for purposes of enrollment in Medicare and in MA plans.

Enhanced Ambulatory Patient Group (EAPG) A payment methodology developed by 3M Health Information Systems for CMS, but also used by some commercial health plans and by many state Medicaid agencies. EAPGs are a more comprehensive successor to APGs. EAPGs are to outpatient procedures what MS-DRGs are to inpatient days. EAPGs provide for a fixed payment to an institution for outpatient procedures or visits based on diagnoses, the procedure or procedures performed, and condition or procedure intensity. Like MS-DRGs, they are also subject to modifiers. EAPGs significantly reduce unbundling of ancillary services. See also Ambulatory Diagnostic Group and Ambulatory Patient Classification.

Enrollee An individual enrolled in a managed healthcare plan. Usually the subscriber or person who has the coverage in the first place rather than his or her dependents, although the term is not always used that precisely.

Enrollment Period A period in which individuals can join or change health plans, as defined by Medicare for MA and Part D coverage, and in the ACA for the open enrollment periods required under the ACA. See also Open Enrollment Period.

Entitlement Program A governmental program such as Medicare or Medicaid, though there are others as well, for which people who meet eligibility criteria have a right to benefits, though some criteria can change but only though the passage of legislation. The state and/or federal government(s) is (are) required to spend the funds necessary to provide benefits for individuals in these programs; in contrast, spending for discretionary programs is set by Congress through the appropriations process. Enrollment in entitlement programs cannot be capped, and neither states nor the federal government may establish waiting lists for joining the programs.

EOB See Explanation of Benefits.

EOC See Evidence of Coverage.

EOMB See Explanation of Medicare Benefits.

EPO See Exclusive Provider Organization.

e-Prescribing When a physician uses electronic means to prescribe drugs.

EPSDT See Early and Periodic Screening, Diagnostic, and Testing.

Equity Model A form of for-profit, vertically integrated healthcare delivery system in which the physicians are owners in full or in part, or have an ownership-like financial interest (e.g., through a leasing arrangement).

ER Emergency room. See Emergency Department.

ERA See Electronic Remittance Advice.

ERISA See Employee Retirement Income Security Act.

ERISA Preemption ERISA preempts state laws pertaining to employee benefits except for insurance, banking, or securities; however, the U.S. Supreme Court further defined the ERISA preemption as limiting any actions or remedies against an insurer to what is defined under ERISA. For example, lawsuits about benefits coverage can award only the cost of the coverage, not additional penalties. For self-funded benefits plans, ERISA preempts state laws in general.

Errors and Omissions Liability Insurance A form of liability insurance companies often have for board members and officers to provide at least partial financial protection against lawsuits based on something that a board member or officer did, or failed to do. The full name is most often Directors and Officers Errors and Omissions (D&O E&O) insurance. See also Claims Made insurance, and Occurrence insurance.

ESRD See End-Stage Renal Disease.

Essential Health Benefits A benefits design under the ACA that includes ambulatory patient services; pediatric services, including oral and vision care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and chronic disease management. The specific definitions of each category be determined by each individual state based on the most commonly sold commercial plans in the individual and small

group markets. As many as four different levels of cost sharing may be applied depending on the level of coverage.

Ethics in Patient Referrals Act Also called Limitation on Certain Physician Referrals (42 U.S. Code § 1395nn). A law prohibiting physicians from referring Medicare patients to diagnostic, therapeutic, or supply services in which the physician has a financial interest. Also known as the Stark Laws after Fortney "Pete" Stark, a now-retired congressional representative from California. The so-called Stark regulations are actually two sets of regulations: Stark I and Stark II. These regulations are not for amateurs to handle, and competent legal counsel is required for any provider system doing business with federal or state governments.

Evergreen Contract A contract that continues in force unless one or both parties give notice of cancellation.

Evidence-Based Medicine (EBM) or Medical Guidelines Clinical practices or guidelines that are based on scientific studies, not habits, hope, or hype. The "gold standard" for EBM guidelines is a randomized clinical trial comparing one treatment to another treatment (or no treatment at all).

Evidence of Coverage (EOC) Also known as a certificate of coverage. A document that describes in detail which healthcare benefits are covered by the health plan, what is excluded, and how benefits are affected by utilization management requirements, medical necessity definitions, and so forth.

Evidence of Insurability A form that documents whether an individual meets creditable coverage requirements to be eligible for health plan coverage when the individual is not enrolling during an open enrollment period for example, when an individual applies for an extension of coverage under COBRA.

e-Visit Electronic visit; an interaction between a provider (usually a physician) and a patient using a secure electronic communications channel rather than face-to-face or via telephone.

Exchange See Health Insurance Exchange.

Exclusion As used in managed care and health insurance, a service or condition for which there will be no (or very limited) coverage.

Exclusion period See Waiting Period.

Exclusive Provider Organization (EPO) A healthcare plan that is similar to an open-access HMO in that it has a limited provider panel, uses an authorization system, and requires members to remain within the network to receive benefits. Unlike traditional HMOs, EPOs usually do not require members to access care through a PCP.

Experience Rating The method of setting premium rates based, totally or partially, on the actual healthcare costs of a group or groups. The amount of the groups experience that is used for premium rate determinations is called Credibility.

Experimental and Investigational Treatment A term used by payers and insurance companies to refer to medical care that is not yet proven or may be the subject of clinical investigation, or that is not a generally accepted practice. Most plans will not cover such treatments unless the patient is enrolled in a qualified investigational trial.

Explanation of Benefits (EOB) A statement mailed to a member or covered insured explaining how and why a claim was or was not paid.

Explanation of Medicare Benefits (EOMB) Because the federal government has its own term for something for which a perfectly good term – EOB – already exists; to give the benefit of the doubt, perhaps it is to distinguish between an EOB from a Medicare intermediary vs. an EOB from a Medicare-supplemental insurance carrier.

External Review The second type of formal appeal of a denial of benefits coverage, in which a panel of physicians who work for an independent organization under contract with a state (or CMS) reviews an appeal and makes a decision that is binding on the payer. It is often required by states, is addressed in ERISA, and is required for all health benefits plans under the ACA.

Extracontractual Benefits Healthcare benefits beyond what the member's actual policy covers that are provided by a plan to reduce utilization or improve outcomes. For example, a plan may not provide coverage for a hospital bed at home, but it might be more cost-effective for the plan to provide such a bed rather than keep admitting a member to the hospital.

F

Facility Fee or Facility Add-on Fee A fee added on to a physician office visit by a hospital or facility

owner. Adding a facility fee to a charge is generally prohibited if the physician owns or leases the office because payments for office visits include that cost (and are specifically built in to the RBRVS payment system). The facility fee is an additional charge that hospitals now bill for care provided by hospital-employed physicians, without lowering the physician's office visit fee. These fees may or may not be covered by health insurance, and payers seek to include clauses in their contracts with hospitals to prohibit add-on fees. Medicare also uses a separate RBRVS calculation for this, but commercial payers may not always do so.

Faculty Practice Plan (FPP) A form of group practice organized around a teaching program. It may be a single group encompassing all the physicians providing services to patients at the teaching hospital and clinics, or it may be multiple groups drawn along specialty lines (e.g., psychiatry, cardiology, or surgery).

FAR See Federal Acquisition Regulations.

Fast Track ED A pathway in the ED allowing minor ailments to be managed quickly, at lower cost, often by nonphysician practitioners.

Favored Nation Clause See Most Favored Nation Clause.

Federal Acquisition Regulations (FAR) The regulations applied to the federal government's acquisition of services, including healthcare services, excluding Medicare. See also Federal Employee Health Benefit Acquisition Regulations.

Federal Employee Health Benefit Acquisition Regulations (FEHBARs) The regulations applied to the Office of Personnel Management's purchase of healthcare benefits programs for federal employees.

Federal Employee Health Benefits Program (FEHBP) The program that provides health benefits to federal employees. See also Office of Personnel Management.

Federal Qualification A term once applied to HMOs and competitive medical plans that met federal standards regarding benefits, financial solvency, rating methods, marketing, member services, healthcare delivery systems, and other standards. Not used since 1995.

Federally Qualified Health Center A health center approved by the government to provide health care to low-income individuals in medically underserved areas.

Fee-for-Service (FFS) A payment arrangement in which a patient sees a provider, the provider bills the health plan or patient, and the provider gets paid based on that bill. In the case of a contracted provider, the maximum payment may be limited to a fee schedule.

Fee Schedule A listing of the maximum fees that a health plan will pay for certain services, based on CPT billing codes. Also referred to as fee maximums, maximum allowable charges, or a fee allowance schedule.

FEHBARs See Federal Employee Health Benefit Acquisition Regulations.

FFS See Fee-for-Service.

Fiduciary A term that applies to employer self-funded benefits plans, the fiduciary is a person or controlling party that manages the assets of the benefits plan and has discretionary powers, and must act solely for the benefit of the plan's beneficiaries, not on behalf of the employer or itself. Some fiduciary responsibilities may be carried out by, or delegated to, an administrator.

File-and-Use Rating Laws State-based laws that permitted insurers to adopt new premium rates without the prior approval of the insurance department. No longer allowed for individual and small group premium rates under the ACA, meaning those rates must be approved first by the state. CMS performs this function for states that cannot or will not conduct premium rate reviews.

Financial Services Modernization Act of 1999 (Pub. Law 106-102) Also called the Gramm-Leach-Bliley Act, legislation that repealed the Glass-Steagall Act of 1933. The Glass-Steagall Act prohibited most U.S. commercial banks from performing investment banking activities such as bringing new debt and equity issues to market, or other such underwriting, and from functioning as insurance companies. In addition to the repeal of Glass-Steagall, the 1999 act allows affiliations between securities firms, banks, and insurance companies.

First-Call Resolution The percentage of contacts resolved on the first call. Typically used in call centers by member services.

First-Dollar Coverage Benefits coverage that has no cost sharing of any type. Under the ACA, benefits

for wellness and prevention must be first-dollar coverage provided in-network, even if cost-sharing applies to other benefits.

First-Pass Rate The percentage of claims auto-adjudicated to completion the first time they go through the claims processing system.

Fiscal Intermediary A company that processes administrative transactions on behalf of the traditional FFS programs in Medicare or Medicaid. The arrangement with such a company may be limited to adjudication and payment of claims, or it may encompass other activities as well.

Flexible Benefits Plan A type of defined contribution benefits plan at a company that allows an employee to select from different options up to a set amount of money, usually through an FSA. Also called a cafeteria plan or a Section 125 plan.

Flexible Spending Account (FSA) A defined contribution benefits plan consisting of a financial account funded with pretax dollars via payroll deduction by an employer. Funds may be used to reimburse the employee for qualified expenses not covered under insurance or through an HRA. FSAs exist for health care and, separately, for childcare services. Unused FSA funds do not roll into following years; they are "use it or lose it" funds except that in some cases, unused FSA funds can roll over into an HSA. FSAs differ from employer-funded HRAs.

Formulary A listing of drugs covered by a health plan, though almost always at differing cost-sharing levels called tiers. A formulary may also indicate drugs that require precertification for coverage, or that are subject to other coverage limitations. There are two types of formularies: *open formularies*, meaning there is at least some level of coverage for drugs not listed in the formulary; and *closed formularies*, meaning there is no coverage for non-formulary drugs, though physicians may request an exception in some cases.

Foundation As applied to managed health care, a nonprofit form of integrated healthcare delivery system. A foundation model system is usually formed in response to tax laws that affect not-for-profit hospitals, or in response to states with laws prohibiting the corporate practice of medicine. The foundation purchases both the tangible and intangible assets of a physician's practice; the physicians then form a medical group that contracts with the foundation on an exclusive basis for services to patients seen through the foundation.

FPP See Faculty Practice Plan.

Fraud and Abuse A term that has been succeeded by the more expansive term Fraud Waste and Abuse. See Fraud Waste and Abuse. See also Abuse or Healthcare Abuse; Fraud or Healthcare Fraud; and Fraud, Waste, and Abuse.*

Fraud or Healthcare Fraud When someone misrepresents or falsifies a fact related to healthcare services to receive payment from a health plan or the government. Abuse may be considered fraud when, for example, someone knowingly misrepresents significant details in delivery of healthcare services or supplies in order to be paid significantly more money. Soliciting, paying bonuses for, or receiving any compensation for referrals or use of goods or services for example, getting a kickback for referring a patient to a specialist or receiving a bonus in return for using a manufacturer's device are also considered forms of fraud.

Fraud, Waste, and Abuse (FWA) Not the name of a law firm or a rock band, this term is used collectively to cover fraud, abusive practices, and wasteful practices by either providers or health plans; a handy catch-all for casting general blame at an industry sector. See also Abuse or Healthcare Abuse; Fraud and Abuse; and Fraud or Healthcare Fraud.

Fronting or Fronting Insurer A commercial insurer that has a market rating and meets state insurance requirements, and that "fronts" for a non-rated insurer or captive insurer while typically taking only 10%–20% of the risk or less.

FSA See Flexible Spending Account.

Full Professional Risk Capitation A physician group or organization that receives capitation for all professional expenses, not just for the services they provide themselves; it does not include capitation for institutional services. The group is then responsible for subcapitating (also called downstream risk) or otherwise paying other physicians for services to their members.

FWA See Fraud, Waste, and Abuse.

* I didn't make all of these combinations up, only note them.

G

Gag Clause A clause in a provider contract that would prevent a physician from telling a patient about available clinical treatment options (i.e., a "gag"). Gag clauses in hospital and physician contracts are like the Sasquatch legendary, big, and scary, but nobody has ever actually found one. Nevertheless, gag clauses are banned under the ACA as well as by many states. Most or all contracts between payers and physicians do contain clauses that prohibit the physician from revealing business secrets such as payment schedules, but this is a different matter. In the past, some contracts did require a physician to contact the payer before initiating a treatment option, which may have been interpreted or treated as such a clause, but the majority of contracts actually require the physician to actively discuss options with the patient. The term "gag clause" may also be used for any confidentiality requirement when a person or organization wishes to use a pejorative term.

Gatekeeper An informal, though widely used term that refers to a primary care case management model health plan. In this model, all care from providers other than the primary care physician, except for true emergencies, must be authorized by the primary care physician before care is rendered. This is a predominant feature of most (but not all) HMOs.

Generic Drug A drug that is equivalent to a brand-name drug, and is usually – but not always – less expensive. Most managed care organizations that provide drug benefits cover generic drugs but may require a member to pay a higher copayment for a brand-name drug.

Genetic Information Nondiscrimination Act (Pub. Law 110-233) (GINA) Legislation passed in 2008 that prohibits discrimination in health coverage and employment based on genetic information. GINA, plus certain provisions of HIPAA, generally prohibit health insurers or health plan administrators from requesting or requiring genetic information of an individual or the individual's family members. This act also prohibits using genetic information for decisions regarding coverage, rates, or preexisting conditions.

Geographic Practice Cost Indices (GPCIs) Used in RBRVS FFS payment methodologies to reflect the relative costs associated with physician work, practice, and professional liability insurance in a Medicare locality compared to the national average relative costs.

GINA See Genetic Information Nondiscrimination Act.

Glass-Steagall Act See Financial Services Modernization Act of 1999.

GLB Gramm-Leach-Bliley Act. See Financial Services Modernization Act.

Global Capitation A situation in which an organization receives capitation for all medical services, including institutional and professional services.

Global Payment Usually refers to a single fixed payment for a defined episode of care in, for example, maternity or surgery. It may be used for either professional or facility payment. When combined with facility payment, it may still be called a global payment but may also be – and often is – called a bundled payment (see Bundled Payment). A confusing term because it may be applied in inconsistent way, so it may be best to avoid it for that reason.

Global Period A period of time defined for each HCPCS code used for physician billing and payment of certain surgical and obstetrical services, and may vary from one day to ninety days depending on the procedure.

Gold Level of Benefits or Gold Plan As defined in the ACA, a qualified health benefits plan with the actuarial equivalent or average of 20% cost sharing, when accounting for deductibles, copayments, and coinsurance as applied to in-network services.

GPCIs See Geographic Practice Cost Indices.

Grace Period The amount of time that a payer must allow a group or individual that has not paid a premium to make good on the payment before the plan cancels the policy all the way back to when payments stopped. If the delinquent company or individual pays up during the grace period, the policy is said to be retroactively reinstated and coverage is considered unbroken.

Gramm-Leach-Bliley Act (Pub. Law 106-102) (GLB) See Financial Services Modernization Act.

Grandfathered Plan A health benefits plan meeting certain criteria that is exempt from some, but not all, of the new requirements under the ACA. A grandfathered plan loses that exemption if it changes in any substantial way.

Grievance A formal complaint by a member about a payer, requiring a response within fixed timelines. It does not apply to appeals of benefits coverage denials (also referred to simply as appeals), which also follow a formal process.

Group The members of a health plan who are covered by virtue of receiving coverage through a single company or organization.

Group Health Insurance A commercial health insurance or HMO policy that is sold to an employer to provide coverage to its employees. This term does not apply to conversion policies or direct-pay policies, nor to Medicare or Medicaid plans.

Group Model HMO An HMO that contracts with a medical group for the provision of healthcare services. The relationship between the HMO and the medical group is generally very close, although there are wide variations in the relative independence of the group from the HMO. A form of closed-panel health plan.

Group Practice According to the American Medical Association, three or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

Group Practice Without Walls (GPWW) A group practice in which the members of the group come together legally but continue to practice in private offices scattered throughout the service area. Sometimes called a clinic without walls (CWW).

Guaranteed Availability, Issue, or Renewal A law that requires insurers to offer and renew coverage, without regard to health status, use of services, or preexisting conditions. The ACA requires these conditions apply to all individuals and employer groups, although the requirement may be limited to open enrollment periods or following a life event.

H

HBP See Hospital-Based Physician.

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems Survey. See also Consumer Assessment of Healthcare Providers and Systems (CAHPS).

HCC See Hierarchal Condition Category.

HCFA See Health Care Financing Administration.

HCFA-1500 See CMS-1500.

HCPCS See Healthcare Common Procedural Coding System (previously HCFA).

HCPT High-Cost Plan Tax. See "Cadillac" plan.

HDHP High-deductible health plan. See also High-Deductible Health Insurance.

Health Care Broadly speaking, means the services that a licensed healthcare professional or facility provides to patients and which is also commonly referred to as medical care, as well as medical goods such as prescription drugs and durable medical equipment. An even broader definition encompasses services from nontraditional providers and more importantly, health care administered by family members or that individuals self-administer, which is actually the majority of health care most people receive but that is not considered a covered benefit by most health plans.

Health Care Anti-Fraud Association A public–private partnership founded in 1985 to combat fraud in health care.

Health Care Financing Administration (HCFA) The old name of the Centers for Medicare & Medicaid Services (CMS).

Health Information Exchange (HIE) An entity to facilitate the electronic exchange of health information between physicians, hospitals, laboratories, payers, and so on. By informal convention, the acronym "HIE" is used for Health Information Exchange, while "HIX" is used for Health Insurance Exchange.

Health Insurance Technically, a health benefits plan for which an insurer is at risk for costs. More loosely it is used by people to refer to any type of health plan. Technically HMOs are not considered health insurance, as they are licensed differently than are insurers through a Certificate of Authority (COA) and are subject to some different regulations, but the general public usually includes HMOs as a form of health insurance. This term is even used to describe self-funded benefits plans in which the employer is at risk for expenses, not an insurance company or an HMO (a legal distinction that is rarely made by most individuals covered by a self-funded plan).

Health Insurance Exchange (HIX or "Exchange") Under the ACA, state-level health

insurance exchanges where individuals and small group employers may purchase qualified health plans. The exchange used by small businesses is referred to as the Small Business Health Options Program (SHOP) that will, or already has, gone away. States may set up and run their own exchanges, they may partner with the federal government to do so, or they may choose to not run their own exchange. If a state does not create an exchange, the federal government steps in to administer it. Provisions in the ACA also allow for multistate health insurance exchanges. By informal convention, the acronym "HIX" is used for Health Insurance Exchange, while "HIE" is used for Health Information Exchange. There are also private health exchanges that bear only a passing resemblance to the public exchanges.

Health Insurance Portability and Accountability Act (Pub. Law 104-191) (HIPAA) Enacted in 1997, part of HIPAA provides benefits coverage issue and continuation rights that have since been made obsolete by provisions of the ACA. More importantly, HIPAA's administrative simplification provisions mandate the use of certain standardized electronic transactions by covered entities, privacy and security requirements, and use of standardized identifiers by covered entities. See also Covered Entities.

Health Insuring Organization (HIO) An organization that contracts with a state Medicaid agency as both a fiscal intermediary and to manage the beneficiaries covered by the HIO. The term may less commonly, and more loosely, be used to refer to health insurers generally.

Health Level 7 (HL7) A designated standards maintenance organization under HIPAA that focuses on electronic connectivity standards for clinical information.

Health Maintenance Organization (HMO) Over the years, the definition of an HMO has changed in some ways. Originally, an HMO was defined as a prepaid organization that provided health care to voluntarily enrolled members for a fixed amount of money on a PMPM basis. That, however, was based on group model HMOs of the time, so years ago it was replaced by language similar to that found in the NAIC Model HMO Act: "Health Maintenance Organization means a person that undertakes to provide or arrange for the delivery of basic healthcare services to covered persons on a prepaid basis, except for a covered person's responsibility for copayment, coinsurance or deductibles." A working definition of an HMO in the current environment could also include the following: It is licensed by the state under a certificate of authority; it is one of the few types of commercial payers that may enter into risk-sharing payment arrangements with providers (not counting Medicare's MSSP program for ACOs, which can have elements of risk); it must meet network access needs that are often more stringent than most other types of payer; it must have strong "hold harmless" language in its provider contracts; it usually (but not always) requires members to go through their PCP to access specialty services; it allows direct access to network PCPs and OB/GYNs; and it has policies and procedures for utilization and quality management that may exceed those found in most other types of payer. In keeping with the morphing meaning of the term HMO, all but the first two of those additional attributes may sometimes now apply to non-HMO payers as well.

Health Outcomes Survey (HOS) or Medicare Health Outcomes Survey (MHOS) A survey that MA plans and providers participating in Medicare must conduct to look at clinical outcomes of covered Medicare beneficiaries. It was once called the Hospital Outcomes Survey.

Health Plan Technically, a health plan is the benefits plan, including its sponsor, not necessarily the administrator of the plan. Said another way, from a technical standpoint, for fully insured policies, the health plan is the insurer or HMO; for self-funded benefits plans, it is the employer and that plan's fiduciary that are considered the health plan, though this distinction is not always made by providers and patients. See also Fiduciary.

Health Plan Identifier (HPID) A uniform health plan identification number required under HIPAA. Originally scheduled for a 2014 implementation date, it has been postponed indefinitely.

Health Reimbursement Account/Arrangement (HRA) A financial account associated with a consumer-directed health plan that is used to pay for qualified healthcare expenses up to a defined limit using pretax funds provided solely by an employer. Unused HRA funds may roll into the next year or may be forfeited at the end of a plan year. Unused

HRA funds do not follow an individual when he or she changes employment. An HRA is always associated with a high-deductible health plan. They are regulated under tax laws.

Health Risk Appraisal (HRA) An instrument designed to elicit or compile information about the health risk of any given individual. Initially these tools were fairly uniform, but some are now specialized and targeted toward particular populations with distinctive risk profiles (e.g., Medicare, Medicaid, underserved, commercial population).

Health Savings Account (HSA) Created under the MMA, an HSA is a financial account containing pretax dollars intended to cover current or future qualified medical expenses, retirement, or long-term care expenses including premiums (but only LTC premiums, not health insurance). Unused funds roll into HSAs for following years. HSAs are used with CDHPs or HDHPs and are funded and used by individuals. Annual contribution limits are defined by the Treasury Department; for example, as of 2019 the contribution limit is $3500.00 for individuals and $7000.00 for families. HSAs are regulated under tax laws.

Healthcare Common Procedural Coding System (HCPCS) A set of codes used by Medicare and other payers that describes services and procedures. The HCPCS is divided into two parts: Level I is the CPT codes maintained by the AMA; Level II includes everything else (more or less) and is maintained by CMS. While HCPCS is nationally defined, there is provision for local use of certain codes. Many of the original HCPCS Level II codes were replaced by special codes in ICD-10, but HCPCS Level I codes were not changed. HCPCS used to stand for HCFA Common Procedural Coding System.

Healthcare Cooperative (co-op) One of the earliest forms of health plans and a forerunner of managed care; a nonprofit organization funded and operated by its members to provide care to co-op members, which reveals its roots in the agricultural co-ops still found in many locales. Healthcare co-ops usually look like prepaid group health plans. Once more common, examples of well-known existing co-ops include Group Health Cooperative of Puget Sound and Group Health Cooperative of Southern Wisconsin. See also CO-OP (note the use of all caps) as defined in the ACA.

Healthcare Effectiveness Data and Information Set (HEDIS) An ever-evolving set of data reporting standards developed by NCQA with considerable input from the employer, provider, regulatory, and managed care communities. HEDIS is designed to provide some standardization in performance reporting of financial, utilization, membership, and clinical data, and more. Medicare and many states accept or require HEDIS data as meeting certain regulatory requirements. Originally called the Health Plan Employer Data Information Set, these standards initially focused on HMOs, but they have since become used by many types of plans. They have also become much more varied, and different versions now exist for commercial, Medicare Advantage, managed Medicaid plans, and other types of organizations.

Healthcare Improvement and Quality Act of 1986 (Pub. Law 99-660) (HQIA) A law that granted physicians performing professional or peer review immunity from monetary damages stemming from quality-related peer review for credentialing and staff appointments. It also created the National Practitioner Data Band.

HFAP See Healthcare Facilities Accreditation Program.

Healthcare Facilities Accreditation Program (HFAP) An accreditation organization focused on osteopathic hospitals.

Healthcare Integrity and Protection Data Bank (HIPDB) An electronic data bank established under HIPAA that records information about providers related to fraud and abuse, criminal convictions, civil judgments, injunctions, licensure restrictions, and exclusion from participation in any governmental programs. Now combined with the National Practitioner Data Bank and called simply "The Databank."

HEDIS See Healthcare Effectiveness Data and Information Set.

HHS See Department of Health and Human Services.

HIE See Health Information Exchange.

Hierarchal Condition Category (HCC) The categories used by CMS for addressing payment changes based on the level of illness in a defined population of beneficiaries, such as those enrolled in an MA plan.

High-Cost Plan Tax HCPT See "Cadillac" plan.

High-Deductible Health Insurance/High-Deductible Health Plan (HDHP) A health benefits plan with very high minimum and maximum annual deductibles; for example, for 2019 the minimum single and family deductibles are $1350.00 and $2700.00 respectively, while single and family maximum deductibles are $6750.00 and $13,500.00 respectively. There are also limits on maximum out-of-pocket costs (see Maximum Out-of-Pocket). The specific amounts are determined each year by the Treasury Department.

High-Risk Pool Programs that were found in some, but not all, states designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. The ACA provided extra funding for states to expand eligibility for uninsurable individuals. Beginning in 2014, guaranteed issue requirements under the ACA made such pools unnecessary for the most part. High-risk pools still exist here and there, however, especially in states that did not expand Medicaid under the ACA and therefore have a group of low-income individuals who have no coverage but who have significant medical problems. Coverage through High-Risk Pools is usually limited compared to regular health coverage. State-level reinsurance is a similar concept, and several states have used that to stabilize their health insurance exchange.

High-Value Plan A high-cost health plan that exceeds cost levels defined under the ACA and, therefore, is subject to an additional tax. Implementation of this added tax has been deferred twice as of the time of publication. Also referred to informally as a "Cadillac" health plan.

HIO See Health Insuring Organization.

HIPAA See Health Insurance Portability and Accountability Act.

HIPDB See Healthcare Integrity and Protection Data Bank.

HIX See Health Insurance Exchange.

HL7 See Health Level 7.

HMO See Health Maintenance Organization.

[The] HMO Act of 1973 (Pub. Law 93-222) A law passed by Congress in 1973 to promote the expansion of HMOs by preempting state anti-HMO laws and requiring large employers to offer at least one closed-panel and one open-panel HMO. This act also required HMOs to offer then-rare comprehensive benefits and abide by community rating requirements. Some elements of the HMO Act are no longer in effect, although the law itself is.

Hold Harmless Clause A contractual clause between a provider and a payer that prohibits the provider from billing a member for charges associated with covered services, other than copayments, coinsurance and/or deductible, even if the payer does not pay anything (i.e., the provider holds the member harmless in the event of nonpayment by the payer).

HOPPS See Hospital Outpatient Prospective Payment System.

HOS See Health Outcomes Survey.

Hospice A program or facility dedicated to palliative care at the end of life. It may consist of a combination of a home-care program, an outpatient facility, and/or an inpatient facility.

Hospital-Based Physician (HBP) A specialty physician who practices primarily within a hospital or ambulatory surgical center in one of five clinical areas: anesthesia, radiology, and pathology (RAPs); emergency medicine, and hospitalists. Traditionally, this term is not applied to hospital-employed physicians in other specialties except if they fit into one of these categories. See also RAPs.

Hospital-Employed Physician The direct or indirect employment of a physician by a hospital or health system. The term could be applied to an HBP, but the more common usage is for other specialties such as primary care, cardiology, and so forth. Employment may be direct or may be done through an intermediate organization such as a captive medical group.

Hospital Inpatient Quality Reporting (IQR) A hospital quality data reporting infrastructure created under the MMA. Used in Medicare's Value Based Purchasing program.

Hospital Outpatient Prospective Payment System (HOPPS) The overall term used by CMS for its different methods of prospective payment to facilities for outpatient care such as surgery, dialysis, and drug administration.

Hospitalist A physician who concentrates solely on hospitalized patients.

HPID See Health Plan Identifier.

HRA See Health Risk Appraisal or Health Reimbursement Account, depending on the context.

HSA See Health Savings Account.

I

IBNR See Incurred But Not Reported.

ICD-9-CM International Classification of Diseases, Ninth Revision, Clinical Modification. ICD-9-CM classifies diseases by diagnosis using six-digit numbers. It was replaced by ICD-10 on October 1, 2015.

ICD-10 International Classification of Diseases, Tenth Revision. ICD-10 replaced ICD-9-CM and several other codes sets on October 1, 2015. There are two versions: ICD-10-CM referring to Clinical Modification, and ICD-10-PCS referring to Procedural Coding System. ICD-10 has up to seven alphanumeric characters, allowing coding of up to 16,000 different diseases, procedures, patient complaints, and other clinical data.

IDN See Integrated Delivery System.

IDS See Integrated Delivery System.

Impaired Insurer An insurer that is in financial difficulty to the point where its ability to meet its financial obligations or regulatory requirements is in question.

Imputed Premium Applies to self-funded plans where no actual premium is paid (other than reinsurance premium) because the self-funded plan bears the risk for costs rather than the insurer. However, even a self-funded plan must budget for expected costs and must determine the amount that should be deducted from an employee's paycheck for his or her portion of the cost of the plan; therefore, an imputed premium is calculated for these purposes. Also called premium equivalent.

In-Office Ancillary Services Exception (IOASE) A loophole that allows physicians to bill Medicare for ancillary services they provide as long as those services are provided in the physician's office. Provisions in the ACA require physicians who own and order certain costly "in-office" services, such as CT or PET scanners, to disclose their ownership to Medicare, and to provide their patients with a disclosure form that also lists alternative providers.

In-Sourcing Bringing back into the payer a process or activity that was once outsourced.

In the Course of Settlement (IOCS) A claim not yet paid, but in process.

Incurred But Not Reported (IBNR) The amount of money that the plan accrues for medical expenses for which medical goods or services were provided but claims have not yet been received, so that enough money is available to pay those claims when they do arrive. Inadequate claims reserves due to faulty or unaccounted for IBNRs have torpedoed more managed care plans than any other cause. Typical causes for inadequate IBNRs include inexperienced managers, faulty information systems, rapid growth, claims backlogs, overly-aggressive financial assumptions, and delusional optimism.

Indemnity Insurance Insurance that "indemnifies" the policyholder from financial losses to at least some degree. In health insurance, this applies to providing financial coverage for healthcare costs. Once common, pure indemnity health insurance plans are quite rare now due to their high costs, though some supplemental policies and out-of-network coverage may be considered a form of indemnity insurance.

Independent Practice Association (IPA) An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA, in turn, contracts with individual providers to provide the services either on a capitation basis or on an FFS basis. The typical IPA encompasses all specialties, but an IPA can be solely for primary care, or it may be single specialty. An IPA may also be the "physician organization" part of a physician–hospital organization.

Independent Review Organization (IRO) An independent group with which a state or a payer contracts to provide a secondary external review of coverage denials based on medical reasons. The use of an IRO for external review is required in most states, and is required for all payers and health plans under the ACA.

Individual Mandate or Penalty An ACA requirement originally in the ACA for all individuals, except for those with a low income, to obtain health insurance of face a financial penalty. The individual

mandate was the other side of the guaranteed issue requirement, so that all individuals, not just the sick ones, would contribute funds to the overall risk pool. Enforcement of the individual mandate was ended in 2018 and Congress eliminated it beginning 2019.

Individual Policy See Direct Pay.

Information Technology (IT) A blanket term referring to all of the computer hardware and software systems that support the operations of a health plan. Virtually all operational functions of a health plan are supported by IT in one way or another. An older term that is still used by some is Management Information System (MIS). See also Medicaid Management Information System (MMIS).

Inpatient Prospective Payment System (IPPS) The name used by Medicare for DRGs and MS-DRGs.

Integrated Delivery System (IDS) Also referred to as an integrated healthcare delivery system or an integrated delivery network (IDN). An organized system of healthcare providers spanning a broad range of healthcare services. In its full flower, an IDS should be able to access the market on a broad basis, optimize cost and clinical outcomes, accept and manage a full range of financial arrangements to provide a set of defined benefits to a defined population, align financial incentives of the participants (including physicians), and operate under a cohesive management structure. See also Accountable Care Organization, Equity Model, Foundation Model, Independent Practice Association, Management Service Organization, Physician–Hospital Organization, and Staff Model.

Intelligent Call Routing or Skill-Based Routing A computer system in a call center or contact center that sends the contact to the customer service representative (CSR) group best prepared to handle the contact. Criteria for routing may include the issue type, severity of the issue, past history of interaction with a specific CSR or set of CSRs, employer group, or other business rules into which have been programmed into the switch (i.e., the computerized telephone system). See also Switch.

Intensivist A type of hospitalist who focuses solely on care provided in the intensive (or critical) care unit.

Intermediary See Fiscal Intermediary.

Investigational Treatment See Experimental and Investigational Treatment.

IOASE See In-Office Ancillary Services Exception.

IOCS See In the Course of Settlement.

IPA See Independent Practice Association.

IPPS See Inpatient Prospective Payment System.

IRO See Independent Review Organization.

IS Information systems. See Information Technology.

I-SNP Institutional Special Needs Plan for Medicare, Medicaid or Dual beneficiaries who are institutionalized in a skilled- or intermediate-care nursing facility, or an assisted living facility. A type of Part C plan.

IT See Information Technology.

J

JCAHO See Joint Commission.

J-Codes A subset of the HCPCS codes used by Medicare, Medicaid, and commercial payers to identify injectable drugs and oral immunosuppressive drugs. May be created on the fly by CMS when a new drug first appears.

[The] Joint Commission (TJC) A not-for-profit organization that performs the majority of accreditation reviews on hospitals, ambulatory facilities, and other types of clinical facilities. Most managed care plans require any hospital under contract to be accredited by The Joint Commission or a similar type of accreditation organization acceptable to Medicare. The old name was the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

K

There are plenty of medical terms and names that begin with the letter K, but none for health insurance and managed care.

L

Lag Study A report related to IBNRs that tells managers the dates of service, processing lag, and

how much is paid out each month attributed to the month services were provided; and then compares these data to the amount of money that was accrued for expenses each month in IBNR reserves. This powerful tool is used to monitor whether the plan's reserves are adequate to meet all expenses. It is often automated. Plans that fail to perform lag studies properly may find themselves descending into the abyss.

Lag Table The tool used by financial personnel to monitor or manage the lag study manually.

Large Case Management (LCM) See Case Management.

Lapse To drop coverage. This may refer to an individual who stops paying premiums, thereby allowing his or her policy to lapse, subject to a grace period. When used as an enrollment ratio, the lapse rate is the percentage of commercially enrolled groups that drop the health plan. It is the opposite of a persistency rate or ratio.

Laser or Lasering Actuarial and underwriting reinsurance slang referring to reducing or eliminating a very specific benefit, including limiting it for an individual in other words, a benefit reduction that is focused like a laser. The more formal term used by reinsurers is a "special limitations" clause. Reinsurance lasering is used mostly in self-funded employee benefits plans, or in at-risk providers and smaller payers that purchase reinsurance. Reinsurance is not health insurance, so it is not subject to all the same regulations as are health insurers or HMOs. A laser does not mean that the self-funded employee benefits plan can also reduce benefits in the same way, which could be considered discriminatory under ERISA, so the employer usually remains liable for benefit costs that are no longer reinsured.

Length of Stay (LOS) The total number of days spent in the hospital for an inpatient admission.

Levels of Coverage Actuarially equivalent cost-sharing levels defined in the ACA as falling into one of four "metallic" categories: Platinum (90% coverage), Gold (80%), Silver (70%), and Bronze (60%). Cost sharing includes all out-of-pocket expenses such as copayments, coinsurance, and deductibles. Costs are determined based only to non-emergency services provided by in-network providers. The ACA also defines a non-metallic level as a type of HDHP available only to individuals under the age of 30.

Life Event See Qualifying Event. See also Special Enrollment Period.

Lifetime Maximum A term, no longer applicable in health benefits plans, for the maximum benefit available under a benefits plan for life; once that maximum was reached, there would be no additional coverage. A common example would have been a $2 million lifetime maximum, so that if an individual with very high healthcare costs reached a point where that much coverage had been spent, that individual had no more coverage. Lifetime maximums are prohibited under the ACA. See also Annual Limit.

Limited Benefits Plan Very low-cost health "insurance" that offers significant limits on benefits by capping the amount that the insurer pays out. For example, it may cap coverage at only $10,000 or $15,000 per year, and may cover outpatient care only up to a set amount of dollars per visit regardless of charges. These plans do not provide adequate coverage for any serious illness or injury and are not considered as qualified plans under the ACA. Also called "Mini-Med" plans.

Line of Business (LOB) A health plan such as an HMO, EPO, or PPO that is set up as a line of business within another, larger organization, such as an insurance company. This legally differentiates it from a free-standing company or a company set up as a subsidiary. It may also refer to a unique product type (e.g., Medicaid) within a health plan.

LIS See Low-Income Subsidy.

LOB See Line of Business.

Lock-in Period The period during which a member cannot switch to another plan. For example, the annual open enrollment for MA plans and PDPs occurs in the fall each year and coverage begins on January 1, but beneficiaries can opt back into traditional FFS Medicare up until February 14 when the lock-in period begins.

Long-Term Care Services needed by people to live in the community, such as home health and personal care, as well as assisted care and institutional care such as nursing homes. Long-term care is not covered by any commercial or self-funded health plan or by Medicare. It is paid for either through special long-term care insurance policies, out of pocket, or by Medicaid for low-income individuals.

LOS/ELOS/ALOS Length of stay/estimated length of stay/average length of stay. See Length of Stay.

Loss Ratio See Medical Loss Ratio.

Low-Income Subsidy (LIS) A subsidy provided for dual-eligible (Medicare–Medicaid) individuals for the Part D drug benefit and for qualified low-income individuals and families purchasing coverage through an exchange.

M

MA See Medicare Advantage.

MA Local Plan A Medicare Advantage managed care plan that does not provide services throughout an entire region as designated by CMS.

MA Regional Plan A Medicare Advantage PPO plan that provides services throughout an entire region as designated by CMS.

MAC See Maximum Allowable Charge or Cost.

MACPAC See Medicaid and CHIP Payment and Access Commission.

MACRA See Medicare Access and CHIP Reauthorization Act of 2015.

Major Diagnostic Category (MDC) Used within the coding conventions for DRGs and MS-DRGs, 23 categories that represent a major system in the body and whether the patient had surgery or not.

Major Medical An old but still used term that refers to health insurance covering physician and many other non-hospitalization services. It can be traced back to the 1940s through the early 1960s when employer-sponsored group health coverage usually covered "hospitalization," meaning hospital costs only. Commercial insurers of the time were essentially mimicking Blue Cross and Blue Shield plans with their historical roots in coverage of services provided by hospitals and physicians, respectively, though even Blue Shield plans might use the term. The term was never applicable to HMOs and became antiquated in 2014 when the ACA's qualified health benefit plans went into effect, but like many antiques it still gets used here and there.

Managed Behavioral Healthcare Organization (MBHO) A third party that manages the behavioral health services benefits for a payer. It may also contract directly with an employer. An MBHO may be at financial risk, or it may manage the services under an administrative contract only. A form of clinical outsourcing.

Managed Care Organization (MCO) A generic term applied to all types of managed care plans. It arose because many believed that it held less negative connotation than did the term HMO. This term was then broadened to encompass plans other than HMOs, such as POS plans, PPOs, EPOs, CDHPs, or any other type of plan that uses elements of managed health care. It has been slowly supplanted by the term "payer" though it still gets used and is imbedded in some laws and/or regulations.

Managed Health Care A somewhat nebulous term referring to a system of healthcare financing, benefits management, and healthcare delivery through contracted providers that tries to manage the cost of healthcare benefits, quality, and access. Common features include a panel of contracted (or in some cases, employed) providers that is less than the entire universe of available providers, some type of limitations on benefits to members who use non-contracted providers (unless authorized to do so) for non-emergency care, some type of authorization or precertification system, provider payment that is typically less than full charges, and no-balance-billing protections for members.

Management Information System (MIS) An older term for information technology (IT). See Information Technology.

Management Service Organization (MSO) A form of integrated health delivery system. Sometimes similar to a service bureau, the MSO may actually purchase certain hard assets of a physician's practice, and then provide services to that physician at fair market rates. MSOs are often formed as a means to contract more effectively with managed care organizations, although their simple creation does not guarantee success.

Mandated Benefits Benefits that a health plan is required to provide by law. This term applies to some benefits required in the ACA such as first dollar coverage for prevention or in-network coverage levels for emergency care. More commonly, however, it applies to coverage required by a state that is condition- or treatment-specific, of specific to a type of provider. There is high variability from state to state. Common examples include in vitro fertilization and other special-condition treatments.

Self-funded plans are exempt from most mandated benefits under ERISA, but even the federal government gets into the act with a mandatory two-day length of stay for childbirth and mental health parity provisions under HIPAA and the ACA, and the ACA's first-dollar prevention benefits that apply to both insured and self-funded plans.

Manual Rate See Book Rate.

MAO See Medicare Advantage Organization.

Margin The amount of money left over, or lost, after costs are subtracted from revenues. Insurers and HMOs have two different types: operating margin and underwriting margin, though the latter applies only to insured business.

Market Conduct Study A type of audit performed by the state that assesses a payer's compliance with state laws and regulations for activities such as marketing and sales, medical management, accessibility, and so forth. It may also be done for MA and managed Medicaid plans.

Market Segment A portion of the total market that may be defined three different ways by the source of funding, by size, and by distribution channel. The two largest entitlement programs, Medicare and Medicaid, each make up a market segment, with the commercial market making up a third segment. Within the commercial market segment, segments are further divided by size into the individual market segment; the small group market segment, meaning employers with at least 1 but no more than 50 full-time equivalent employees; and the large group market. Some payers add a mid-sized segment for groups of 50 to several hundred. Distribution channels are similar to market segmentation by size, but focus on differences such as direct sales, sales through brokers, or involving benefits consultants.

Markup Fee A type of add-on provider fee in which their cost to obtain something is marked up by a percentage amount. For example, a physician administering intravenous chemotherapy in the office may charge for the office visit, for the administration of the chemotherapy, and for the drugs and IV solutions at cost plus 50%. Medicare and many commercial health plans limit the markup fee to approximately 6%. Markup limitations may also be used with Reference Pricing (see Reference Pricing).

Master Group Contract The actual contract between a health plan and a group that purchases coverage. The master group contract provides specific terms of coverage, rights, and responsibilities of both parties.

Master Member Index (MMI) A database used to identify in a reliable manner each member, or in medical management to identify each patient receiving care from a particular physician.

Maximum Allowable Charge or Cost (MAC) The maximum amount that a vendor will be paid for something. Maximum Allowable Cost is usually used in pharmacy contracting, while Maximum Allowable Charge is used for provider payment. Also referred to as Maximum Allowed Fees or Fee Maximums.

Maximum Out-of-Pocket Cost (MOOP when used by CMS for Parts A and B in an MA plan) The most amount of money a health plan member will ever need to pay out of pocket for covered services during a contract year, not including premium costs. The maximum out-of-pocket cost includes deductibles, copayments, and coinsurance. Once the maximum is reached, cost-sharing stops. For plans other than MA, maximum out-of-pocket cost limits are set by the Treasury Department; for example, in 2019 the maximum is $6750.00 for single coverage and $13,500.00 for family coverage. The MOOP for MA is determined by CMS using the 95th percentile of projected beneficiary out-of-pocket spending.

MBHO See Managed Behavioral Healthcare Organization.

McCarran-Ferguson Act of 1945 (15 U.S.C. §§ 1011–1015) Federal legislation that established (by default) that states had the authority and responsibility to regulate the business of insurance without federal government interference, and that allows states to establish mandatory licensing requirements. This act also contains a limited antitrust exemption allowing insurers to share certain underwriting information for purposes of rate development; but states had prevented health insurers and HMOs from doing this already, but nevertheless there have been several attempts to repeal this part of the Act for health insurers and HMOs.

MCE See Medical Care Evaluation.

MCO See Managed Care Organization.

MDC See Major Diagnostic Category.

MEC See Minimum Essential Coverage.

Medicaid The federal entitlement program under Social Security Act Title XIX that is funded jointly by the states and the federal government, and which provides health and long-term care coverage to certain categories of low-income Americans; it was enacted in 1965 at the same time as Medicare. States may design their own programs within broad federal guidelines. Medicaid eligibility was expanded under the ACA, but states are not required to comply. See also Medicaid Expansion.

Medicaid and CHIP Payment and Access Commission (MACPAC) A commission created by the ACA to focus on Medicaid payment policy. MACPAC is similar to MedPAC, which focuses on Medicare payment policy.

Medicaid Expansion The portion of the ACA that increased eligibility for Medicaid coverage by requiring states to expand Medicaid eligibility standards to a consistent level, with the federal government assuming 100% of the cost until 2016, after which the federal government will assume 90% of the cost. The U.S. Supreme Court, along with ruling that the ACA was constitutional, removed Medicaid expansion as a requirement for states. Consequently, some states have not undertaken this expansion of coverage.

Medicaid Management Information System (MMIS) The mechanized claims processing and information retrieval system that states are required to have, unless this requirement is waived by the Secretary of Health and Human Services.

Medicaid Waivers A waiver of federal law that allows a state to opt out of the standard Medicaid fee-for-service program and adopt a managed care approach to financing and providing healthcare services to Medicaid-eligible recipients. It usually requires that some of the savings be applied to broaden coverage of who is eligible for Medicaid. There are four types of Medicaid waiver authorities that states can apply for: Section 1932(a), Section 1915(a), Section 1915(b), and Section 1115 (the most commonly used type of Medicaid waiver).

Medical Care Evaluation (MCE) A component of a quality assurance program that looks at the process of medical care. The term is now archaic but was used specifically when HMOs were federally qualified.

Medical Home See Patient-Centered Medical Home.

Medical Loss Ratio (MLR) The ratio between the amount paid out for medical benefits and the amount of money that was taken through premium payments. It applies only to fully insured or at-risk business. See also Medical Loss Ratio Limitations.

Medical Loss Ratio (MLR) Limitations The ACA sets limits on the MLR for several types of insured, but not self-funded, health plans. The MLR limit is 80% for individual and small group (with fewer than 50 employees) coverage, and 85% for groups with 50 employees or more, MA plans, and managed Medicaid plans. Delegated administrative activities are included. If the MLR is below those levels, the plan must rebate the difference; if it is above these levels, the plan must absorb any losses that may result and may not recover it later by raising rates. The MLR depends on both the amount of money brought in through premiums and the cost of the benefits provided.

Medical Policy or Medical Payment Policy Industry term that is not consistent from payer to payer, and that differs from how the term "health policy" is used generally. From a payer's operational point of view, it is the set of internal rules about what will be paid for as medical benefits under certain circumstances. Routine medical payment policy is linked to routine claims processing and is typically automated. For example, the plan may pay an assisting or second surgeon at 50% of the primary surgeon's payment, or a plan may not pay for two surgical procedures done during one episode of anesthesia.

Medical Savings Account or Medicare Set Aside account (MSA) A specialized savings account, with a slightly different name for commercial accounts than for Medicare, into which a consumer can put pretax dollars for use in paying medical expenses in lieu of purchasing a comprehensive health insurance or managed care product. MSAs were created as a demonstration under BBA'97 and updated in the MMA. Both commercial and Medicare MSAs require a catastrophic health insurance policy or HDHP as a "safety net" to protect against very high costs (an MA HDHP for Medicare). They still exist, but have been supplanted by HSAs and HRAs in CDHPs that are similar in approach but have additional features that make them more attractive to the market. MSAs for Medicare are

a type of Part C plan, but cannot offer Part D coverage have never been popular.

Medically Necessary or Medical Necessity The policies used for benefits determinations when medical services or products may or may not be covered depending on certain criteria. Typical criteria used include being necessary to protect or preserve the health of an individual; being based on evidence-based clinical standards of care; not being primarily for the convenience of the patient or physician; not more costly than an alternative service or sequence of services at least as likely to produce equivalent results; not experimental or investigational care, except in defined circumstances; not considered custodial care or care that is essentially assistance with acts of daily living; and not considered medically appropriate by generally accepted standards of medical practice. "Medically necessary" is defined in the evidence of coverage document for all benefits plans; although those definitions are generally similar, they are typically not exactly the same.

Medicare The federal entitlement program under Social Security Act Title XVIII under which health benefits coverage is provided by the federal government for citizens older than the age of 65 as well as some others, such as individuals with end-stage renal disease. Regular Medicare is a fee-for-service type of insurance; *Part A* covers hospital care and is the only mandatory part of the Medicare benefit, while *Part B* covers professional services. *Part C* authorizes private plans such as Medicare Advantage. *Part D*, passed under the MMA, provides a drug benefit. Traditional fee-for-service Medicare is administered by intermediaries on behalf of CMS, while Parts C and D come through various forms of private plans.

Medicare Advantage (MA) The overall name of the various types of approved Part C private plans authorized to voluntarily enroll Medicare beneficiaries.

Medicare Secondary Payer (MSP) A Medicare rule in which Medicare is secondary to another payer, usually a commercial or an MA plan.

Market Conduct Study A type of audit performed by the state that assesses a payer's compliance with state laws and regulations for activities such as marketing and sales, medical management, accessibility, and so forth. It may also be done for MA and managed Medicaid plans.

MDC See Major Diagnostic Category.

Meaningful Use Medicare's minimum standards for using EHRs; and for exchanging patient clinical data between providers, payers, and patients, though not all at the same time or in the same way. Compliance with Meaningful Use requirements has an effect on CMS payment in traditional Medicare.

MEC See Minimum Essential Coverage.

Med. Sup. See Medicare Supplemental benefits plans.

Medicare Access and CHIP Reauthorization Act of 2015 (Pub. Law 114-10) (MACRA) A law authorizing funding for a continuation of the CHIP program that also contained a complicated new VBP program for provider payment in traditional FFS Medicare. Components include the QPP, MIPS, and APMs. Some or all of those payment methodologies may be changed or even gone by the time you read this, so check up-to-date sources as needed.

Medicare Advantage (MA) Created as part of the MMA, a program that replaced the prior term Medicare+Choice and expanded other forms of Medicare managed care. MA plans may be HMOs, PPOs, or PFFS plans; they may also be local or regional. Special needs plans were also created to focus on specific types of beneficiaries. MA medical savings accounts are also overseen under MA.

Medicare Advantage MSA Plan (MA MSA) A non-network-based Medicare Medical Savings Account plan coupled to an MA HDHP plan. See also Medical Savings Account or Medicare Set Aside account.

Medicare Advantage Organization (MAO) CMS's overall term used to refer to the various types of MA plans.

Medicare+Choice The old name for Medicare private insurance options, created under BBA '97 (Pub. Law 105-33); most often applied to Medicare HMOs at the time. The clunky name Medicare+Choice was replaced by Medicare Advantage under the MMA.

Medicare Improvements for Patients and Providers Act of 2008 (Pub. Law 110-275) (MIPPA) A law that reduced overpayments to the MA plan, required MA private FFS plans to establish

networks, changed Part D marketing practices, and added preventive benefits (pre-ACA), among other things. It also reversed the rapid expansion of MA PFFS to an equally rapid decline.

Medicare Limiting Charge The maximum calculated Medicare FFS allowed payment to physicians not participating in Medicare, set at 115% of 95% of the Medicare maximum allowable payment.

Medicare Modernization Act of 2003 (Pub. Law 108–173) (MMA) The federal act originally titled the Medicare Prescription Drug Improvement and Modernization Act of 2003. The MMA is the basis for both the Medicare Part D drug benefit and for the variety of Medicare Advantage (MA) plans described elsewhere, including MA Local, MA Regional, and MA PFFS.

Medicare Payment Advisory Commission (MedPAC) An independent congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. The Commission's statutory mandate is to advise Congress on payments to providers in Medicare's traditional fee-for-service program and private health plans participating in Medicare, and to analyze access to care, quality of care, and other issues affecting Medicare.

Medicare Recovery Audit Contractors (RAC) Auditors under contract with CMS to review the appropriateness of data supporting payment.

Medicare Severity Diagnosis-Related Groups (MS-DRGs) A system implemented by Medicare to replace traditional DRGs. MS-DRGs not only are based on the diagnosis and procedures performed, but also take into account other chronic conditions and comorbidities, including those that are major. The intent in developing this system was to reduce the number of cases classified as outliers.

Medicare Shared Savings Program (MSSP) A payment methodology in traditional fee-for-service Medicare in which an ACO is paid as usual, but an overall cost target is calculated for a cohort of individuals with high medical costs who are "assigned" to the ACO. Unlike in an HMO, there is no lock-in, meaning beneficiaries are not required to use the ACO for care. The ACO shares in a portion of any savings compared to that target. Tier 1 is single-sided, meaning the ACO only shares in savings. Tier 2 is two-sided meaning that the ACO shares a higher percentage of savings but also shares risk in that it must repay a portion of any costs in excess of the target.

Medicare Supplemental Plans A Medicare supplemental insurance sold and administered by private companies that covers some of what Medicare does not. Policies are subject to standards and restrictions under federal law, and must be 1 of 10 different benefits plan designs, labeled A through N (plans E, H, I, and J are no longer allowed). Because they are supplemental only, Medicare Supplemental plans are still allowed to perform medical underwriting and reject applicants with pre-existing conditions. Also called MediGap or Med. Sup.

Medication Therapy Management (MTM) A program to ensure optimal therapeutic outcomes and reduced adverse events for targeted beneficiaries through improved medication use. MTM is required under the MMA for Part D sponsors.

MediGap Medicare Supplemental benefits plans.

MedPAC See Medicare Payment Advisory Commission.

Member An individual covered under a managed care plan. May be either the subscriber or a dependent. See also Subscriber.

Member-Months The total number of members covered each month, added together. For example, if a plan had 10,000 members in January and 12,000 members in February, the total member-months for those two months would be 22,000.

Member Services The department that directly interacts with members, not including the actual provision of health care. Examples of member services include resolving problems, managing disputes by members about coverage issues, and managing the grievance and appeals processes. Member services may also function in a proactive manner, reaching out to members with educational programs, self-service capabilities, and the like. Known in other industries as customer services.

Mental Health Parity Act of 1996 The initial federal legislation that required annual or lifetime dollar limits on mental health benefits to be no lower than dollar limits for medical and surgical benefits offered by a group health plan. This act did not apply to benefits for substance abuse or chemical dependency, however. It was superseded by the

Mental Health Parity and Addiction Equity Act of 2008 (see below).

Mental Health Parity and Addiction Equity Act of 2008 (Pub. Law 110-343) Federal legislation that requires group health plans and health insurance issuers to ensure that financial requirements (such as copayments and deductibles) and treatment limitations (such as visit limits) for mental health or substance use benefits are no more restrictive than those used for medical/surgical benefits. Provisions of this act were strengthened under the ACA, which also eliminated the annual and lifetime limit for all benefits, including mental health and addiction services.

MEOB See Medicare Explanation of Benefits.

Merit-Based Incentive Program (MIPS) Part of the QPP under MACRA, a form of professional provider VBP in the traditional FFS Medicare program. It was on shaky ground at the time of publication.

Messenger Model A type of integrated delivery system (IDS), usually a physician–hospital organization, that simply acts as a messenger between a payer and the providers participating in the IDS in regard to contracting terms. It does not have the power to collectively bargain, thus avoiding antitrust violations.

MET Multiple employer trust. See Multiple Employer Welfare Association.

MEWA See Multiple Employer Welfare Association.

MFN See Most Favored Nation Clause.

MHOS See Hospital Outcome Survey.

MHS See Military Health System, or Multihospital System as appropriate.

Midlevel Practitioner (MLP) Physician's assistants, clinical nurse practitioners, nurse–midwives, and the like; non-physicians who deliver medical care, generally under the supervision of a physician but for less cost. The term has been declining in use over the past several years.

Military Health System (MHS) A large and complex healthcare system designed to provide, and to maintain readiness to provide, medical services and support to the armed forces during military operations and to provide medical services and support to members of the armed forces, their dependents, and others entitled to Department of Defense medical care. See also TRICARE.

Mini-Med See Limited Benefits Plan.

Minimum Creditable Coverage The minimum level of health benefits coverage from any source necessary for an individual to be considered insured under the requirements of the ACA.

Minimum Essential Coverage (MEC) A provision of the ACA defining the least amount of coverage that individuals were required to have to avoid a penalty. Congress eliminated this penalty as of 2019. Roughly equivalent to minimum creditable coverage.

Minimum Premium Plan A once-common type of insurance plan for large employer groups that closely resembles self-funding, in which the employer is responsible for claims costs up to a certain level, which is usually very high. After that, the insurer is at risk, similar to reinsurance. With the advent of ERISA, minimum premium plans have largely been replaced with self-funded plans and reinsurance.

Mini-Med Plan A type of defined contribution plan that covers a fixed dollar amount for a limited number of medical services, and does not meet the ACA's minimum standard requirements for coverage. May be used short-term in place of an adequate plan in some instances.

MIPPA See Medicare Improvements for Patients and Providers Act of 2008.

MIPS See Merit-Based Incentive Program.

MIS See Management Information System.

Mixed Model A managed care plan that mixes two or more types of delivery systems. This term has traditionally been used to describe an HMO that has both closed-panel and open-panel delivery systems.

MLP See Midlevel Practitioner.

MLR See Medical Loss Ratio.

MMA See Medicare Modernization Act.

MMI See Master Member Index.

MMIS See Medicaid Management Information System.

Model of Care (MOC) The MOC is a scored set of standards that SNPs must meet under a provision of the ACA. MOC standards are based on standards created by NCQA. SNPs must achieve a minimum score of 70% to pass, and at least 75% to be able to contract with CMS for more than one year.

Modified Adjusted Gross Income (MAGI) How an individual's income is determined under the ACA for purposes of coverage subsidies and/or eligibility for Medicaid coverage.

MOC See Model of Care.

Modifier A standardized billing code used with CPT-4 or HCPCS codes for some types of procedures and services that reflects different costs or difficulties associated with patient-specific differences or variable costs.

MOOP See Maximum Out-of-Pocket; used for MA plans.

Moral Hazard In the context of insurance, changes in the behavior of an insured individual (or organization) caused by the existence of insurance itself, such that the behavior change may increase costs to the insurer. The word moral refers to a state of mind (e.g., "moral support"), and hazard may refer to a dice game that is the forerunner of craps. There are four overlapping but distinct expressions of moral hazard: asymmetric knowledge, the pooling of unequal risks, induced demand (which has two of its own forms or expression), and the agent-principal problem.

Most Favored Nation (MFN) Clause A clause in a contract between a payer and a health system that requires the health system to give the payer the best rate; in other words, a clause that prohibits the health system from giving any nongovernmental payer a more favorable rate than it gives the payer. Once commonly used by large hegemonic payers such as Blue Cross and Blue Shield plans that had most of the business in a state, MFN clauses are now illegal in many states, although they are not necessarily considered anticompetitive in all situations.

MSA See Medical Savings Account or Medicare Set Aside account.

MS-DRG See Medicare Severity Diagnosis-Related Groups.

MSO See Management Service Organization.

MSP **See** Medicare Secondary Payer.

MSSP See Medicare Shared Savings Program.

MTM See Medication Therapy Management.

Multihospital System (MHS) A health system with multiple hospitals.

Multiple Employer Trust (MET) or Multiple Employer Welfare Association (MEWA) A group of employers that band together for purposes of creating a self-funded health benefits plan to avoid state mandates, premium taxes, and insurance regulation. Another form of this is the Association Health Plan. Once regulated little, if at all by the states, they subsequently came under state regulation when they appeared to operate as small insurers. METs and MEWAs are otherwise subject to the ACA in the same manner as any self-funded benefits plans. In the past, many did not have the financial resources to withstand the risk of medical costs and have failed, leaving their employees and their dependents without coverage. They also risk having employer groups with low costs leave the MEWA to avoid subsidizing the cost of coverage for employer groups with high costs, putting the MEWA into a death spiral. MEWAs and METs are also more susceptible to fraud than traditional insurance or a single employer self-funded benefits plan.

Multiplier See Conversion Factor.

Mutual Insurance Company, Mutual Insurer, or Mutual Companies with no capital stock, which are owned by policyholders. The earnings of the company over and above the payments of the losses, operating expenses, and reserves are the property of the policyholders.

N

NADDI See National Association of Drug Diversion Investigators.

NAIC See National Association of Insurance Commissioners.

National Association of Drug Diversion Investigators (NADDI) A nonprofit organization that facilitates cooperation between law enforcement, healthcare professionals, state regulatory agencies, and pharmaceutical manufacturers in the prevention and investigation of prescription drug diversion.

National Association of Insurance Commissioners (NAIC) An organization that represents all of the state insurance departments and that formulates model insurance laws and regulations. Provisions of the ACA require the Secretary of Health and Human Services to seek the recommendations of the NAIC for many elements of the U.S. healthcare insurance system.

National Committee on Quality Assurance (NCQA) A nonprofit organization that performs accreditation reviews on HMOs and other types of managed care plans such as PPOs. They offer accreditation, certification, and recognition programs for other things such as disease management programs, CVOs, PCMHs, and so forth. NCQA also developed and maintains the HEDIS standards.

National Council for Prescription Drug Programs (NCPDP) An organization that developed and maintains accepted electronic data interchange standards for pharmacy claims transmission and accelerated adjudication adoption of pharmacy e-commerce. These standards permit the submission of pharmacy claims and the adjudication of those claims in a real-time interactive mode. The NCPDP standards are recognized by ANSI and addressed under HIPAA.

National Drug Code (NDC) The national classification system for identifying prescription drugs.

National Guidelines Clearinghouse (NGC) A database once run by the AHRQ until it was senselessly and idiotically shut down in 2018 after its funding was cut.

National Health Plan Identifier See Health Plan Identifier.

National Practitioner Data Bank (NPDB) A data bank established under the federal Health Care Improvement and Quality Act of 1986, which electronically stores information about physician malpractice suits successfully litigated or settled and disciplinary actions upon physicians. The NPDB is accessible by hospitals and health plans under controlled circumstances as part of the credentialing process. Hospitals and health plans must likewise report disciplinary actions to the data bank. It is now combined with the Healthcare Integrity and Protection Data Bank and called simply "The Databank."

National Provider Identifier (NPI) An identification number mandated under HIPAA, which replaced most other types of provider identifiers regardless of the type of customer (e.g., commercial health plan, Medicare, Medicaid, TRICARE). The NPI does not replace the DEA number or the tax ID number of a provider, however.

National Quality Forum (NQF) A not-for-profit, public–private organization created to develop and implement a national strategy for healthcare quality measurement and reporting. This voluntary consensus standards-setting organization addresses quality measurements in patient care, electronic health records, patient safety, and so forth.

Navigator Under the ACA, a qualified entity that helps consumers and employers understand their options and select coverage through state health insurance exchanges. Underfunded from the start, states that even provide navigators have seen federal funding fall even more, causing a reduction or elimination of this service.

NCPDP See National Council for Prescription Drug Programs.

NCQA See National Committee on Quality Assurance.

NDC See National Drug Code.

NDP See Notice of Denial of Payment.

Net Worth See Statutory Net Worth.

Network Adequacy, or Network Adequacy Standards Access standards specifying the minimum number of providers in a specific geographic area that an HMO or other type of network-based payer must have to be able to market and sell in that area. Alternatively, drive times may be used to set the access standards. Access standards differ for PCPs and specialists, general and specialty hospitals, and urban and rural areas. For physicians, only those with open practices may be counted. Also called Access Standards.

Network Model HMO A health plan that contracts with multiple physician groups to provide health care to members. Another name used for open-panel HMOs. There was once a type of "true network" HMO that contracted with only a limited number of large medical groups, but that model blended with other forms of contracting and the term became too blurred to use anymore.

Never Events See Serious Reportable Events.

NGC See [the late, great] National Guidelines Clearinghouse.

NHCAA See Health Care Anti-Fraud Association.

NIO See Non-investor Owned.

Nonadmitted Asset An asset owned by an insurer or HMO that does not count toward its statutory net worth or as statutory capital under SAP rules. The understanding of this term may vary slightly from

state to state, but it usually is applied to assets that cannot be readily converted into cash in the event of a health plan failure. It may also apply to only a portion of an asset; for example, no more than 5% of a plan's statutory net worth can consist of such assets as computers, real estate, and so forth.

Non-investor Owned (NIO) An insurer that is not a for-profit company, but is not technically a nonprofit charitable organization. It is most often a type of mutual insurer or mutual reserve company.

Nonpar Slang that is short for a nonparticipating (non-contracted) provider.

Notice of Denial of Payment (NDP) A form that CMS requires MA plans to use when notifying a beneficiary that a payment for a service is being denied, why it is being denied, and what the beneficiary's appeal rights are.

NPDB See National Practitioner Databank.

NPI See National Provider Identifier.

Null Claim A claim submitted by a capitated provider that is used only to collect encounter data, not for purposes of payment.

O

Occurrence Insurance or Reinsurance A type of professional liability or malpractice insurance, including D&O E&O insurance. Occurrence means that the insurer or reinsurer has liability if the policy was in force when the event occurred, regardless of whether the professional had notified the insurer. It differs substantially from another common form of professional liability known as claims made, and from a less common type of reinsurance called claims paid. See also Claims Made Reinsurance or Insurance, Directors and Officers Errors and Omissions Insurance, and Claims Paid Insurance or Reinsurance.

OCR See Office for Civil Rights or Optical Character Recognition, depending on the context.

Office for Civil Rights (OCR) A department within the U.S. Department of Health and Human Services charged with enforcing HIPAA privacy and security standards, among other things.

Office of the Inspector General (OIG) A branch of each major federal agency that is responsible for conducting internal and external investigations and audits, including on federal contractors or any system that receives funds or payment from the federal government. There are several OIG departments in different federal programs; examples pertinent to managed health care would include DHHS, DOL, TRICARE, CMS, and the FEHBP.

Office of Personnel Management (OPM) The federal agency that administers the FEHBP. A health insurance or managed care plan must contract with the OPM under the FEHBARS in order to be offered to federal employees.

OIG See Office of the Inspector General.

OOBD See Order of Benefits Determination.

Open Access An HMO that does not use a primary care physician "gatekeeper" model to manage access to specialty physicians. In other words, a member may self-refer to a specialty physician rather than seeking an authorization from their PCP. HMOs that use an open-access model typically have a significant copayment differential depending on the physician from whom care is received. Also called direct access.

Open Enrollment Period The period when an employee may change health plans, a Medicare Beneficiary can enroll in or change Medicare Advantage (MA) or PDP plans, or an individual or small group can apply for coverage under guaranteed issue. Open enrollments usually occur once per year. Open enrollment takes place for all individual and small group guaranteed issue, all MA, and a little over half of all large employer group coverage in the fall of each year for an effective date of January 1.

Open Formulary See Formulary.

Open-Panel HMO A managed care plan that contracts (either directly or indirectly) with private physicians to deliver care in their own offices. Examples would include a direct contract HMO and an IPA-model HMO.

Operating Margin The amount of money left over, or lost, after subtracting all costs from all revenues. It generally does not include the cost of taxes, but does include investment revenue or losses; it also may or may not include subsidiaries depending on if it's the operating margin for subsidiary or for all subsidiaries at the corporate parent level.

OPL See Other Party Liability.

OPM See Office of Personnel Management.

Opt Out (1) A managed care benefits design in which a member can opt out of using the plan's network and still receive some coverage for medical services. For example, a point-of-service plan may be considered an HMO with an opt-out benefit. (2) A brief period after the MA open enrollment period during which a Medicare beneficiary can opt out of an MA plan and go back to the traditional Medicare FFS plan.

Optical Character Recognition (OCR) A system of hardware and software that is able to recognize written characters scanned in from a paper source and convert those characters into standard data used for electronic processing. This technology is used in any processing systems in which paper forms (e.g., claims and enrollment forms) may be submitted. Data scanned in via OCR are usually flagged by the machine if there is a possibility or error and subsequently checked by clerks for accuracy and corrections. OCR is more efficient than keying the data in manually.

Order of Benefits Determination (OOBD) A COB term for determining the order of responsibility for payment when an individual has benefits coverage from more than one source.

Organization Provider The term used by NCQA and some other organizations to describe healthcare facilities for example, hospitals, ambulatory care centers, dialysis centers, and so forth.

Out-of-Pocket Any amount of money spent by a member on benefits. This term is usually synonymous with cost sharing, but some sources include payroll deductions in the category as well. See also True-Out-of-Pocket Cost (TrOOP), the term used by CMS for benefits under MA plans.

Other Party Liability (OPL) A condition in which another party is responsible for paying for costs. The most common examples are worker's compensation and automobile liability policies. See also Coordination of Benefits.

Other Weird Arrangement (OWA) Some type of benefits plan, product design, payment scheme, or network contract that some bright person or consultant* has created but for which there is no precedent, no track record, and no easy means of implementation.

Outlier Something that is outside of a range; something that is significantly more or less than expected. This term is used in two ways. (1) Provider payment methodologies in which the provider receives a fixed amount of money for a procedure or for services. Outliers used in hospital payment methods are usually based on Chargemaster "costs" or charges, and additional payments made on a discounted basis. Outliers for physician payment are commonly used for PCP capitation and provide protection to the PCP's risk pool against very high cots. (2) An outlier may also refer to a provider who is using medical resources at a much higher rate than his or her peers.

Outsourcing An arrangement in which a process or activity that a payer provides is handled by a contracted third party. It is somewhat broader than the term Business Process Outsourcing, which includes such activities as contracting with an off-shore company to manually enter data from images of paper claims. Outsourcing may also include medical management functions such as managing behavioral health utilization, or network management such as contracting and managing a provider network.

OWA See Other Weird Arrangement.

P

P4P See Pay for Performance.

PA Prior Authorization; see Precertification.

PACE See Programs for All-Inclusive Care for the Elderly.

Package Pricing An older term for bundled payment. See Bundled Payment.

Part D The drug benefit created under the MMA and provided by a private, free-standing prescription drug plan (PDP) or included in an MA plan as an MA-PDP.

Partial Hospitalization A hospital stay that lasts between 4 and 23 hours.

Participating Provider A contracted provider.

* Including your author, earlier in his career.

Patient-Centered Medical Home (PCMH) The term used by CMS and others to refer to a form of coordinated care through the use of designated clinical teams. The medical home concept put forth by a joint statement by the AAFP, ACP, AAP, and AOA and was initially called a Primary Care Medical Home (and is still called that in the ACA). PCMH emphasizes four primary care elements accessibility, continuity, coordination, and comprehensiveness which research shows positively affect health outcomes, satisfaction, and costs. Most well-run group-model HMOs have offered PCMHs for decades. Sometimes simply called Medical Home.

Patient Protection and Affordable Care Act (Pub. Law 111-148) (ACA) An act signed into law by President Barack Obama in 2010 that was a sweeping overhaul of the rules under which health insurance may operate and requirements for all types of health benefits plan. Some requirements apply only to fully insured plans, while others apply to both fully insured and to self-funded plans. The ACA also contains many provisions beyond those that directly affect health coverage, including changes in funding for primary care, payments to hospitals, and changes to Medicare Advantage and to Medicaid. Changes in political control in Congress and then the White House have led to many ACA provisions being "de-funded," modified, or dropped altogether but efforts to repeal the ACA have not succeeded as of the time of publication.

Patient Safety and Quality Improvement Act of 2005 (Pub. Law 109-41) (PSQIA) A law creating Patient Safety Organizations (PSOs) and a national safety database. It also provided confidentiality protections for professional activities related to quality of care and patent safety (called a patient safety work product).

Patient Safety Organization (PSO) (1) A type of organization created by the PSQIA and described by federal rules in which clinicians and healthcare providers can work to collect, aggregate, and analyze data within a legally secure environment of privilege and confidentiality protections to identify and reduce patient care risks and hazards. AHRQ administers provisions governing PSO operations, and DHHS's Office for Civil Rights enforces confidentiality provisions. (2) PSO was used in the past for Provider-Sponsored Organization, a type of provider organization created as a pilot under the BBA'97 that contracted with Medicare on an at-risk basis without being an HMO. PSOs' goal was to "cut out the middleman," but quickly discovered that it isn't called "risk" for nothing, and most ended up as a financial heap of smoking rubble and ticking metal.

Patient's Bill of Rights (PBR) A law or policy that describes the rights a patient has regarding his or her health care and how he or she should be treated, and that may be applied to either a provider or a payer. A voluntary PBR is often posted by hospitals. Some states also have PBR legislation regarding health insurers. In the 1990s, the U.S. Congress made several attempts to pass a PBR, but never succeeded. With the passage of the ACA, various provisions falling under the broad category of consumer protections are now called a Patient's Bill of Rights.

Pay and Chase/Pay and Pursue A term (with an interchangeable third word) that is commonly used with COB. It means that when COB is involved the health plan first pays the claim and then tries to recover all or some of the claims cost from the other insurer. The antonym is Pursue and Pay/Chase and Pay. See also Chase and Pay and Coordination of Benefits.

Pay for Performance (P4P) The provision of financial incentives to providers (hospitals and/or physicians) to improve compliance with standards of care and to improve outcomes and patient safety. A type of VBP but usually with fewer dollars and less affected by cost measures.

Payer or Payor Generic term applicable to any commercial health insurer or benefits administrator that pays medical claims. Payor was more commonly used through the early 2000s after which Payer began to be used more widely. This book generally uses the term Payer, but either term is acceptable.

Payment The term that should always, always, always be used instead of "reimbursement" when referring to provider payment. Reimbursement applies to actual out-of-pocket costs incurred such as being reimbursed for the cost of business travel. Payment is the amount of money one party pays to another and that is affected by negotiating leverage and an agreement between a willing buyer and a willing seller (at least when contractually

based); payment amounts affect behavior, including bonuses and the like, and payment terms are usually kept confidential between the parties.

PCCM See Primary Care Case Manager.

PCMH See Patient-Centered Medical Home.

PCP See Primary Care Physician.

PDP See Prescription Drug Plan.

Peer Review Organization (PRO) The old name for organizations charged with reviewing quality and cost for Medicare; it has since been replaced by Quality Improvement Organization (QIO).

PEL See Provider Excess Loss.

Pend or Pended A term used in claims processing referring to a claim being held while additional information is sought before final adjudication. Some payers use *pend* to refer to claims put on hold by a claims examiner, and *suspend* for claims put on hold by the system. As a practical matter, pend and suspend are nearly the same. See also Suspend.

PEPM Per Employee per Month. In the context of health plans, the subscriber is either a single individual in the case of single coverage; in the case of family coverage, the subscriber is the individual that obtains the coverage but not the individuals dependents. Members are the combination of the subscriber and the subscriber's dependents.

Per Diem [Payment] Payment of a facility, usually a hospital, based on a set rate per day rather than on charges. Per diem payment can be flat, varied by service (e.g., medical/surgical, obstetrics, mental health, and intensive care), or by day (e.g., first day per diem is higher than remaining days). Payments may also be affected by carve-outs and outliers; see both terms elsewhere in the Glossary.

Per Member per Month (PMPM) The average total revenue, cost, or unit of utilization across all enrolled members for a month. One of the most commonly used acronyms in health insurance and managed care. To use a simple example, if an HMO has 100 members and during the year one member incurs $180,000 in hospital expenses, another member incurs $90,000 in hospital expenses, and a third member incurs $45,000 in hospital expenses, the HMO's PMPM hospital costs would be $262.50 PMPM, as seen in the following simplified equation: [(($180,000 + $90,000 + $45,000) ÷ 12) ÷ 100] = $262.50. In reality, the calculations must account for monthly variations in membership, the impact of cost-sharing and different benefits designs, and many other variables.

Per Member per Year (PMPY) The average revenue, cost, or unit of utilization across all enrolled members for a year. It is the same concept as PMPM but one does not divide by 12 months. It is used when PMPM gives too small a result.

Per Thousand Members per Year (PTMPY) The same basic concept as PMPM and PMPY but per thousand members, not per member; and annualized as if spread out over a year regardless of the time span measured. The most common way of reporting facility-based utilization such as hospital utilization, which is expressed as Bed Days per Thousand Members per Year, Bed Days per Thousand, or abbreviated as BD/K.

Persistency The percentage of commercial groups that stay with a payer organization from year to year. A persistency of 90 would mean that 90% of covered groups did not change insurers or leave the plan for any reason.

Personal Health Record (PHR) Unlike an EHR created by a physician or health system that contains notes, lab values, imaging, and so forth, the PHR is typically an individual health record that is most often created by a health plan using its available data. The sources of those data include provider claims, prescription drug claims (usually from a PBM), demographic data, and so forth. Clinical data such as results of diagnostic lab tests or imaging may be provided if the plan has access to it, and members can usually add other data such as drug allergies or the results of a health risk appraisal. Because of fragmentation of the healthcare system in the U.S., the PHR may provide the most comprehensive source of certain types of information such as prescribed drugs for an individual. The purpose is to provide at least a usable subset of important health-related information in an electronically portable or transmittable format to improve continuity of care and emergency care.

PFFS See Private FFS Plan.

PHI See Protected Health Information.

PHO See Physician–Hospital Organization.

PHR See Personal Health Record.

PHSA See Public Health Service Act.

Physician–Hospital Organization (PHO) An organization that represents hospitals and its attending medical staff, developed to contract with managed care plans. A PHO may be open to any members of the medical staff who apply, or it may be closed to some for various possible reasons.

Physician Incentive Program (PIP) A generic term referring to a payment methodology under which a physician's income from a payer (or an IDS) is affected by the physician's performance or the overall performance of the plan (e.g., utilization, medical cost, quality measurements, member satisfaction). This term has a very specific usage by the CMS in limit placed on the degree of individual physician incentive or risk allowed in an MA HMO. CMS essentially bans "gainsharing" via a PIP altogether in IDSs receiving payment under Medicare. Some states also have laws and regulations limiting PIPs. PIP incentives must also be disclosed to members of a plan for which a PIP applies. See also Significant Financial Risk.

Physician Practice Management Company (PPMC) An organization that manages physicians' practices, and in most cases either owns the practices outright or has rights to purchase them in the future or has some other type of long-term contractual relationship with the practice. PPMCs concentrate only on physicians and not on hospitals, although some have also branched into joint ventures with hospitals and insurers, and many hospitals have created their own PPMCs for acquired practices in which the physicians are not directly employed by the hospital. Most PPMCs in the late 1980s through the 1990s failed, but some still exist, particularly for single specialties. Others morphed into MSOs, and the trend towards hospitals employing physicians has led to some increase in its use.

Physician Quality Reporting System (PQRS) A program under Medicare in which physicians report data on selected measures of quality and receive an incentive payment.

Physician Self-Referral The practice in which a physician refers a patient for a costly service or procedure that uses a facility or equipment in which the physician has a financial interest and profits from its use. It is strongly associated with utilization levels well above those seen on a case-matched basis but in which a physician has no financial interest. In the earliest days of HMOs, self-referral meant a member's consultation of a specialist without getting a PCP authorization, but that use of the term is now archaic though it still appears from time to time.

Physician Work ("Work") Used in the RBRVS physician payment methodology to reflect the amount of effort, training and stress associated with performing specific procedures or services.

PIP See Physician Incentive Program.

Place of Service (POS) Code A code on a claim form indicating the type of facility in which a medical procedure was performed. Not to be confused with a Point of Service plan.

Platinum Level of Benefits or Platinum Plan As defined in the ACA, a qualified health benefits plan with the actuarial equivalent or average of 10% cost sharing, when accounting for deductibles, copayments, and coinsurance as applied to in-network services.

PMPM See Per Member per Month.

PMPY See Per Member per Year.

POD See Pool of Doctors. Alternatively, see *Invasion of the Body Snatchers*, starring Kevin McCarthy and Dana Wynter and directed by Don Siegel (Allied Artists Pictures, 1956); it has nothing to do with health care, but does have pod people.

Point of Service (POS) A benefits plan design that combines features of an HMO with some level of coverage for out-of-network non-emergency services. A triple option POS plan has progressively diminishing levels of coverage based on the type of network involved, including an HMO, a PPO and an indemnity (when the provider is not in a network). A dual option POS plan does not have the PPO level. Members must use the HMO system to obtain the highest level of benefits; out-of-network services are also covered but with higher cost sharing than seen in a PPO. See also Place of Service Code.

Pool of Doctors (POD) A system usually used with payment in which physicians are grouped into units smaller than the entire panel, but larger than individual practices, to diminish the impact of random chance. Typical PODs have between 10 and 30 physicians. The POD is typically not a legal entity, but rather a grouping done by an external party unless the POD is based on an existing physician organization such as a medical group.

Pooling See Risk Pool.

Portability The ability of people to obtain coverage as they move from job to job or in and out of employment.

Portal A single Internet website providing access to multiple other sites and/or functionalities. For example, payers in a region may jointly offer a single sign-on portal for providers to use for checking a patient's coverage eligibility, or for use with the authorization and claims systems. Also called an Internet portal.

POS See Point of Service.

PPACA See Patient Protection and Affordable Care Act.

PPMC See Physician Practice Management Company.

PPO See Preferred Provider Organization.

PPS See Prospective Payment System.

PQRI Physician Quality Reporting Initiative; the pilot program replaced by the Physician Quality Reporting System (PQRS).

PQRS See Physician Quality Reporting System.

Practice Expense (PE) Used in the RBRVS payment methodology to reflect the cost of running a physician's practice.

Preauthorization See Authorization. See also Precertification.

Precertification The process of obtaining certification or authorization from the health plan for routine hospital admissions or for ambulatory procedures. It often involves an appropriateness review against criteria and assignment of length of stay. Failure to obtain precertification often results in a financial penalty to either the provider or the subscriber. Also known as preadmission certification, preadmission review, and pre-cert. Also called Prior Authorization (PA).

Preemption The term for federal laws taking precedence, or preempting, state laws.

Preexisting Condition A medical condition for which a member has received treatment prior to becoming covered under a health plan. Prior to 2014, preexisting conditions disqualified people from purchasing individual health insurance, but that practice is prohibited by the ACA.

Preferred Provider Organization (PPO) A plan that contracts with independent providers at a discounted payment rate. The panel is limited in size and usually has some type of utilization review system associated with it. A PPO may be risk bearing, like an insurance company, or may be non-risk bearing, like a rental PPO that markets itself to insurance companies or self-insured companies via an access fee. See also Rental PPO.

Premium The money paid to a health plan for coverage by the insurer; i.e., the insurer is at risk for medical costs. This term may be applied on an individual basis or a group basis. See also Imputed Premium.

Premium Compression or Premium Rate Compression The result of a law or regulation placing limits on how much difference is allowable between the highest and lowest premiums. The ACA allows no more than a threefold difference in rates charged to individuals. Premium rate compression is a means of subsidizing the cost of covering less healthy individuals. Confusingly, it may also be used to refer to what is defined here as Premium Cost Compression.

Premium Cost Compression The reduction in the difference between what a health plan is able to charge in premiums and what it costs to pay for medical benefits. This situation may be a result of regulatory or competitive market forces. It not only reduces the plan's ability to generate a positive underwriting margin, but also reduces the ability to withstand errors or cost overruns. Confusingly, it may be used to refer to what is defined here as Premium Compression or Premium Rate Compression.

Premium Deficiency See Premium Insufficiency.

Premium Equivalent See Imputed Premium.

Premium Insufficiency An insurer's failure or inability to charge enough in premiums to cover medical benefits and administrative costs. Out-of-control administrative costs can cause this gap, but it also commonly occurs when benefits costs rise higher than the level expected when the premium rates were originally calculated. This situation is particularly dangerous because an insurer must live with a premium insufficiency for the entire year that the policy is in place, so losses mount each month the policy or policies remain in force. In the individual and small group markets, insurers are not allowed to any recovery of losses from premium insufficiency in any upcoming premium rates.

Premium Tax A tax levied by a state on insurance premiums for policies sold in that state. Employers that self-fund their health benefits plan, as well as Medicare Advantage plans, are not subject to state premium taxes. The same term may be used for a tax fee imposed on all types of health benefits plans under the ACA.

Premium Tax Credits The way that subsidies are provided to qualified low-income individuals and qualified small businesses to help offset the premium cost of health insurance; in the case of individuals, it is only obtainable when coverage is purchased through a health insurance exchange.

Prepaid or Prepayment Payment for services before they are incurred. Capitation is a form of prepayment, in that the provider is paid before the month in which services will be provided; premiums for insured products are also prepaid before coverage goes into effect. HMOs and early Blue Cross plans were once called prepaid health plans because money paid in advance of the HMO or the hospital providing the service were considered a way to pay providers, but one that happens before rather than after care is provided.

Prescription Drug Plan (PDP) A private plan approved by CMS in which Medicare beneficiaries may voluntarily enroll to obtain Part D drug coverage. PDPs do not provide coverage for other services. When an MA plan also offers Part D coverage, it is called an MA-PD.

Preventive Care Health care that is aimed at preventing complications of existing diseases or preventing the occurrence of a disease.

Primary Care Case Manager (PCCM) A term used in Medicaid managed care programs. It refers to having a designated PCP be a case manager for a Medicaid beneficiary and coordinate care, for which the PCP is paid using traditional Medicaid FFS plus an ongoing nominal management fee such as $5 or $10 PMPM.

Primary Care Physician (PCP) Generally, an internist, pediatrician, family physician, or (rarely) a general practitioner. Obstetrician/gynecologists may function like a PCP for some women.

Prior Authorization (PA) See Precertification.

Private Fee-for-Service Plan (PFFS) A type of MA plan in which a private insurance company accepts risk for enrolled beneficiaries, but pays providers on an FFS basis that does not have any risk component to the provider. PFFS plans originally did not use networks or comply with many MA requirements but now must do both. Because of the added network and reporting requirements, and reductions in payment from CMS, PFFFs sharply declined in numbers and new represent a small fraction of the MA market.

Private Health Insurance Exchange An insurance exchange run by an insurer, brokerage, or a benefits management consulting firm that may be used by employers to offer different options to their employees, or by insurers to offer options to employer groups. It is not the same as a health insurance exchange under the ACA.

Private Inurement What happens when a nonprofit business operates in such a way as to provide more than incidental financial gain to a private individual; for example, if a nonprofit hospital pays too much money for a physician's practice or fails to charge fair market rates for services provided to a physician. This practice is prohibited by the Internal Revenue Service for nonprofits and prohibited by CMS for all of Medicare.

PRO See Peer Review Organization.

Producer In health insurance and managed care, a broker or agent who sells a plan's policies to businesses and individuals.

Professional Liability Insurance (PLI) Another term used to refer to malpractice insurance.

Professional Services Agreement (PSA) A contract between a physician or medical group and an integrated delivery system or payer for the provision of medical services.

Profiling Measurement of a provider's performance on selected measures, with that performance then being compared to the performance of similar providers. Profiling is usually applied to physicians. It may be used for purposes of network selection or tiering, feedback reports, and/or P4P or VBP programs, but is very complicated to perform properly.

Programs for All-Inclusive Care for the Elderly (PACE) A federally funded program to facilitate community resources to help seniors who are state certified as needing nursing home care, but who can live safely in their communities with assistance.

Prospective Payment System (PPS) Medicare's terminology for determining fixed pricing for

payment of hospitals and facilities for care. The most well-known examples of PPS are DRGs, MS-DRGs, and APCs. Prospective payment may be used by commercial plans, as it applies to payment of facilities using the same methodologies. May also be called the HPPS as applied to hospitals.

Prospective Review A review intended to determine whether a medical service will be covered before the care is rendered. See also Precertification.

Protected Health Information (PHI) That information that reveals medical information or data about an individual. PHI is addressed specifically by HIPAA in the Privacy and Security sections.

Provider The generic term used to refer to anyone providing medical services. In fact, it may even be used to refer to any*thing* that provides medical services, such as a hospital. Most often, however, this term is used to refer to physicians.

Provider Excess Loss (PEL) A stop-loss or reinsurance insurance policy purchased by risk-bearing provider organizations, full-risk-bearing medical groups, or integrated delivery systems to limit their exposure to catastrophic claims costs.

Provider-Sponsored Organization (PSO) An archaic term referring to an entity allowed under the BBA'97 as a pilot program. A PSO was a risk-bearing managed care organization owned and operated by providers that contracted directly with CMS (HCFA at the time) to cover Medicare enrollees. PSOs were the result of a belief by providers and legislators that there were fat profits to be had through "cutting out the middleman" that is, by removing the HMO from the equation. With a few small exceptions, PSOs failed utterly and lost considerable amounts of money. The federal waiver authority for PSOs expired quietly in 2002. CMS recycled the PSO acronym and it now stands for "Patient Safety Organization."

Prudent (or Reasonable) Layperson Standard According to the ACA, "a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine," could reasonably expect "to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part." The ACA requires health plans to provide unrestricted in-network benefits regardless of whether the provider is in- or out-of-network under this definition of an emergency.

PSA See Professional Services Agreement.

PSO See (1) Patient Safety Organization (current) or (2) Provider-Sponsored Organization (archaic).

PTMPY See Per Thousand Members per Year.

Public Health Service Act of 1944 (Pub. Law 78-410) (PHSA) A federal law that established the role of the federal government in preventing transmittable diseases. It has been amended constantly since then, and many other laws derive their authority from the PHSA for example, considerable portions of HIPAA, the ACA, and numerous medically related laws.

Pursue and Pay See Chase and Pay.

Q

QA, QM, or QI Quality Assurance, Quality Management, or Quality Improvement. See Quality Management.

QBP See Quality Bonus Program.

QHP See Qualified Health Plan.

QIO See Quality Improvement Organization.

QIP See Quality Improvement Program.

QISMC See Quality Improvement System for Managed Care.

QPP See Quality Payment Program.

Qualified Health Plan (QHP) As defined in the ACA, a health plan that is certified by a state health insurance exchange, provides the ACA-defined essential health benefits and cost-sharing limitations, is licensed by the state, and offers at least one Gold-level and one Silver-level benefits plan through the exchange. See also Essential Health Benefits and Health Insurance Exchange.

Quality Bonus Program (QBP) The star-rating bonus program for MA plans. It covers multiple measures in five broad areas: (1) wellness and prevention, including screenings, tests, and vaccines; (2) managing chronic conditions; (3) member experience and satisfaction; (4) member complaints and plan performance changes; and (5) customer service.

Qualifying Event An event in a person's life that makes him or her eligible for coverage outside of the

usual eligibility periods; for example, childbirth or adoption of a child, or losing coverage as a consequence of losing employment, divorce, and others. Sometimes also called a Life Event. See also Special Enrollment Period.

Quality Improvement Expenses Under the ACA, health plan costs associated with improving quality may be considered as a medical cost instead of an administrative cost, for purposes of calculating the MLR.

Quality Improvement Organization (QIO) An organization under contract to CMS to conduct quality reviews of providers, respond to beneficiary complaints about care, measure and report performance of providers, ensure that payment is made only for medically necessary services, and carry out other functions. Its work applies to all types of plans and services, not just managed care.

Quality Improvement Program (QIP) The quality improvement program put in place by CMS for Medicare Advantage plans of all types. The QIP uses data from HEDIS, HOS, and CAHPS, as well as financial and member disenrollment data. Accreditation by NCQA is also considered under the QIP.

Quality Improvement System for Managed Care (QISMC) A now-discontinued CMS program focusing on quality of care and member satisfaction for Medicare risk plans. It was replaced by the Quality Improvement Program.

Quality Management (QM) An umbrella term that may also go by names such as Quality Assurance and Quality Improvement; the last of which is attached to several government quality-related programs as well. A set of policies and procedures designed to assess the quality of care and services measurable by a payer, and to institute improvement changes as appropriate.

Quality Payment Program (QPP) A part of MACRA that put in place a form of VBP affecting how some providers are to be paid in the traditional FFS Medicare program.

Qui Tam Sui A provision in tort law that allows a citizen to file suit on behalf of the (federal) government, and to collect one-third of the proceeds of a successful government lawsuit or settlement. Such suits are usually also subject to treble damages, making success a lucrative endeavor.

Quota Share Reinsurance A form of reinsurance in which a percentage of claims costs are the responsibility of the reinsurer. A contract for quota share reinsurance is usually referred to as a Treaty.

R

RAC See Medicare Recovery Audit Contractors.

RAP Radiology, Anesthesia, Pathology. Three common types of hospital-based physicians that often have near-monopoly control over their specialties within a hospital, and that patients/members have little ability to choose from.

RAPS See Risk Adjustment Processing System.

RARCs See Remittance Advice Remark Codes.

Rate Band Premium rates charged to all individuals within a specific age group, such as all individuals between the ages of 41 and 50. Rate banding reflects the average costs incurred by those in each age group, and are lower for the young and healthy, and progressively rising as the age band gets older. The ACA does not prohibit rate banding, but restricts the rate spread to a maximum of 3:1.

Rate Spread The difference between the highest and lowest premium rates within a risk pool for example, all individual subscribers or small employer groups.

Rating or Premium Rating The process by which the health plan develops its premium rates.

RBC See Risk-Based Capital.

RBRVS See Resource-Based Relative Value Scale.

Rebate In general usage, the return of some money to a purchaser. Under the ACA MLR limitations, if an insurer spends less than 80% on paying for benefits in the individual and small group market, or 85% in the large group market, it must rebate the difference to the purchasers. Another common use applies to pharmaceutical manufacturers rebating some part of the purchase price to PBMs, plans, employers, or government based on volume.

Rebundlers Software programs that roll up and reprice fragmented bills as well as apply industry-standard claims adjudication conventions.

Reference Pricing A pricing method in which the maximum allowable payment is based on the lowest available market price, not what was charged.

Such pricing is usually applied to biologics and other pharmaceuticals, as well as devices, but is sometimes also used for facility and professional services.

Regional Health Information Organization (RHIO) A nongovernmental entity that facilitates the flow of electronic health information between different organizations such as physicians, hospitals, and payers. A better concept than a reality because health systems or payers are not eager to provide easy access to their data by competitors, thereby lowering a market barrier. See also Health Information Exchanges.

Reimbursement A term commonly but incorrectly used to refer to payment of healthcare providers. Reimbursement is more applicable to something like an employer covering an employee's out-of-pocket travel costs on a dollar-to-dollar basis. The relationship of what it costs to provide care and how much a provider is paid is approximate at best, and payers (e.g., Medicare, Medicaid, HMOs, and PPOs) do not all pay the same amount for the same billing codes or to the same providers. The more accurate term in health care, therefore, is payment, not reimbursement. Repeat as Necessary: It's Not Reimbursement; It's Payment.

Reinstatement The situation in which an insurance coverage is restored after payment for delinquent premiums during a defined grace period. See also Grace Period.

Reinsurance Insurance purchased by a health plan, self-funded employer group, or at-risk provider system to protect it against extremely high-cost cases. See also Stop Loss.

Relative Value Units (RVUs) Numeric values used as multipliers to calculate the payment to a provider. RVUs may be used for time units such as for anesthesia, but their most common use is as part of the Resource-Based Relative Value Scale.

Relative Value Scale Update Committee (RUC) A committee of the American Medical Association that reviews the weights placed on the relative value units in the Medicare RBRVS every 5 years. CMS usually uses its recommendations to adjust payment rates.

Remittance Advice Remark Codes (RARCs) Standardized codes required under HIPAA that inform providers what was covered by the plan, how much (if anything) is being paid by the plan, and how much the provider must collect from the member.

Rental PPO A PPO network owned and managed by a third party that rents access to the network (and often services such as claims repricing) to a payer or a self-funded employer group. It is not the same as a risk-bearing PPO that combines a network with the insurance function.

Rescission The retroactive rejection of an issued insurance policy "for cause." The ACA places severe restrictions on rescissions, limiting it mostly to instances of fraud.

Reserves The amount of money that a health plan puts aside to cover healthcare benefits costs. It may apply to anticipated costs such as IBNRs, or it may apply to money that the plan does not expect to have to use to pay for current medical claims but keeps as a cushion against future adverse healthcare costs. Reserves can include only admitted assets under SAP, not GAAP. See also Admitted Assets, Nonadmitted Assets, and Risk-Based Capital.

Resource-Based Relative Value Scale (RBRVS) A relative value scale developed originally for the CMS for use by Medicare. The RBRVS assigns relative value units (RVUs) to each CPT code based on the level of skill and complexity required for that procedure, including office visits. Smaller RVUs are also assigned based on costs associated with the setting in which the care was provided, and for the cost of malpractice insurance. The RVUs are then added together and multiplied by a dollar-amount conversion factor to calculate the actual payment. Commercial versions exist as well to cover procedures not typically used by Medicare.

Retail Clinic A type of urgent care clinic, usually located in a drug store or grocery store, that is often staffed by nonphysician primary care providers who provide care for routine illnesses (e.g., sore throat), but are limited in what they can do. Such care is often less expensive than a physician office visit, and it reduces primary care providers' income. Also called a convenient care clinic (CCC).

Retention (1) That portion of a health insurance premium that goes toward administrative costs and reserves, not medical claims costs (most common use). (2) Persistency (less common use). (3) Student

recall of information found in this text (degree of usage unknown).

Retrospective Review A review of healthcare costs or utilization after the care has been rendered. Several forms of retrospective review are possible. One form looks at individual claims for medical necessity, billing errors, fraud, or for other reasons. The other form looks at patterns of costs and utilization rather than individual cases.

RHIO See Regional Health Information Organization.

Rider An add-on to the core insurance or HMO policy for example, coverage for vision services.

Risk Adjustment A methodology to account for the health status of patients when predicting or explaining costs of health care for defined populations or for evaluating retrospectively the performance of providers who care for them. Risk adjustment is also used by CMS in the payment of MA plans. Also known as HCC severity adjustment and acuity adjustment. Case mix is a related term.

Risk Adjustment Processing System (RAPS) A data file system used by CMS until around 2009 as the basis for Medicare Advantage member risk scores; replaced by Encounter Data System (EDS) data files. Not to be confused with RAPs (Radiology, Anesthesia, Pathology physicians).

Risk-Based Capital (RBC) A formula embodied in the Risk-Based Capital for Health Organizations Model Act, created under the auspices of the NAIC. RBC takes into account the fluctuating value of plan assets; the financial condition of plan affiliates; the risk that providers may not be able to provide contracted services; the risk that amounts due may not be recovered from reinsurance carriers; and general business risks (i.e., expenses may exceed income). The RBC formula gives credit for provider payment arrangements that reduce underwriting risk, including capitation as well as provider withholds, bonuses, contracted fee schedules, and aggregate cost arrangements. While not required in all states, RBC is the primary agreed-upon standard for insurance departments to determine whether a health plan meets the minimum financial statutory solvency requirements.

Risk Contract A contract between a health plan and the CMS under Medicare Advantage under which the health plan is at risk for the cost of medical services to voluntary Medicare beneficiaries, and receives a monthly payment in return. Also known as a Medicare risk contract.

Risk Corridor The upper and lower limits of financial risk for a health plan or provider that is at risk for medical costs. Both limits must exist for the arrangement to be considered a risk corridor. A risk corridor of 20%, for example, would mean that the plan or provider can have financial losses or gains of no more than 10% of the baseline payment.

Risk Management (1) As applied to the management of a health plan's operations, steps taken to reduce the risk of litigation or regulatory sanctions for example, working with a member who has experienced a negative event in which the health plan may have had a role. (2) Steps taken to manage the overall risk of healthcare costs (i.e., managing the insurance risk). (3) Obtaining various forms of liability insurance (unrelated to medical claims costs) for financial protection in case of a lawsuit. (4) Reducing medical errors (provider only).

Risk Pool (Risk-Based-Payment) In the context of capitation or risk-based FFS, a pool of funds that may be drawn against to cover medical costs, with unused funds being paid to a provider or providers according the preset performance standards. See also Rule of Small Numbers.

Risk Pool (Premiums) In the context of premiums, a group of individuals (e.g., all individual subscribers, employees in a group, or Medicare enrollees) who all put in the same amount of money, thereby spreading out the risk even though some are healthier and some are sicker. Also called pooling. Risk pools for premiums are addressed specifically in the ACA.

RUC See Relative Value Scale Update Committee.

Rule of Small Numbers The notion that predictions that are based on large numbers are usually reasonably accurate, but as the numbers get smaller, chance plays a far more important role until eventually chance completely outweighs predictability.

RVU See Relative Value Unit.

S

Safe Harbor The circumstances under which a hospital or other healthcare entity can provide

something to a physician or other health entity and not violate the anti-kickback portion of the Stark laws and regulations. See also Ethics in Patient Referrals Act.

SAP See Statutory Accounting Principles.

SBC See Summary of Benefits Coverage.

Schedule of Benefits The listing in the evidence of coverage document of what is and what is not covered by a health plan, and under which circumstances.

SCHIP See State Children's Health Insurance Program.

SCP See Specialty Care Physician.

Second Opinion An opinion obtained from a physician regarding the necessity for a treatment that has been recommended by another physician. It may be required by some health plans for certain high-cost procedures. Once required by insurers for a broad array of procedures.

Section 125 Plan A plan that allows employees to receive specified benefits, including health benefits, on a pretax basis. Section 125 plans enable employees to pay for health insurance premiums on a pretax basis, whether the insurance is provided by the employer or purchased directly in the individual market. See also Flexible Benefits Plan.

Section 1115 Waiver See Medicaid Waiver.

Self-Care The series of steps that "lay" individuals take to assess and treat an illness or injury, typically without the benefit of higher levels of training in the theory or science of medicine and with little or no consultation with a medical professional.

Self-Insured or Self-Funded Plan A health plan where the risk for medical cost is assumed by the employer rather than an insurance company or managed care plan. Self-funding makes up the majority of employer-sponsored coverage. Under ERISA, self-funded plans are exempt from most state laws and regulations such as premium taxes and mandatory benefits. State and municipal employee benefits plans are also often self-funded, though under state laws, not ERISA. Self-funded plans are also exempt from some, but not all, of the requirements created under the ACA. Self-funded plans typically contract with insurance companies or third-party administrators to administer the benefits. See also Administrative Services Only.

Self-Referral See Physician Self-Referral.

Sentinel Effect The phenomenon that when it is known that behavior is being observed, that behavior changes, often in the direction the observer is looking for. For example, utilization management systems and profiling systems often lead to reductions in utilization before much intervention even takes place, simply because the providers know that someone is watching.

Serious Reportable Events (SREs) Also called "Never Events," medical errors that occur in a facility (hospital or ambulatory surgical center) that should never happen. An example of a "never event" is amputation of the wrong limb. Maintained by the National Quality Forum, definitions of serious reportable events are grouped into seven categories: surgical, product or device, patient protection, care management, environmental, radiologic, and criminal. Medicare as well as most payers will not pay for care required as a result of a "never event."

Service Area The geographic area in which managed care plans provides access to medical care through contracted providers. The service area is usually specifically designated by the regulators (state or federal), and the plan is prohibited from marketing outside the service area. It may be defined by county or by ZIP code. An HMO might potentially have more than one service area, and the service areas might be either contiguous (i.e., they border each other) or noncontiguous (i.e., there is a geographic gap between them). Also referred to as Network Adequacy. Service area is also a term used by Blue Cross and Blue Shield plans to apply to the geographic locations in which they may market and sell using the BCBS marks and signs.

Service Bureau (1) A form of IDS or MSO in which a hospital or other organization provides services to a physician's practice in return for a fair market price; it may also try to negotiate with managed care plans, but is generally not considered to be an effective negotiating mechanism. (2) An older term used for a service plan.

Service-Level Agreement (SLA) The part of a contract specifying performance standards such as average speed to answer telephone calls or percentage of claims processed within 14 days. An SLA is often part of an administrative services-only contract between a large self-funded employer group

and a payer. It is also commonly found in a contract between a payer and a company providing outsourced services.

Service-Level Percentage A measurement in a call center of the specific percentage of calls to be answered within a given timeliness goal.

Service Plan A prepaid health plan made up of contracting providers, but that is not necessarily a managed care plan. The archetypal service plans are traditional (i.e., non-managed care) Blue Cross and Blue Shield plans, although a few non-Blue service plans do exist. The contract applies to direct billing of the plan by providers (rather than billing of the member), a provision for direct payment of the provider (rather than reimbursement of the member), a requirement that the provider accept the plan's determination of UCR and not balance bill the member in excess of that amount, and a range of other terms. Similar to a PPO, but usually has a larger network and little or no UM or QM.

SFR See Significant Financial Risk.

Shadow Pricing The practice of setting premium rates at a level just below the competition's rates, whether or not those rates can be justified. This practice is generally considered unethical and, in the case of community rating, possibly illegal.

Shared Savings See Medicare Shared Savings Program.

SHMO See Social Health Maintenance Organization.

Shock Claim A very costly episode of care for an individual member; also referred to as a catastrophic claim or "cat claim" for short. Shock claims are taken into account by actuaries to varying degrees when they determine the trends for medical costs because shock claims, while costly, are infrequent and have a certain amount of randomness to them.

Shoe Box Effect A practice in which beneficiaries save up their receipts of self-paid claims to file for reimbursement at a later time (e.g., by saving those receipts in a shoe box). Those receipts are sometimes lost, or the beneficiary never sends them in, in which case the insurance company does not have to reimburse the member.

SHOP See Small Business Health Options Program.

Significant Financial Risk (SFR) A term used by the CMS that refers to the total amount of a physician's income at risk in a Medicare HMO. Such financial risk is considered "significant" when it exceeds a certain percentage of the total potential income that physician could receive under the payment program. SFR most commonly is defined as any physician incentive payment program that allows for a variation of more than 25% between the minimum amount and the maximum amount of potential payment.

Silent PPO A form of rental PPO that a payer did not clearly identify by having the PPO's name or logo on the member's ID card. A provider without a contract with the payer would bill for full charges, but the rental PPO's payment terms would be applied to pay the claim, resulting in unanticipated reductions in the provider's booked revenue. This practice, which is now rarely used, is considered either unethical or illegal, and payers that use rental networks typically now include that PPO's logo somewhere on the ID card. See also Rental PPO.

Silver Level of Benefits or Silver Plan As defined in the ACA, a qualified health benefits plan with the actuarial equivalent or average of 30% cost sharing, when accounting for deductibles, copayments, and coinsurance as applied to in-network services.

Single-Payer System A healthcare system in which the government, or an intermediary functioning on behalf of the government, pays for all healthcare services. It is financed through taxes and/or healthcare premiums collected by the government or intermediary. It is usually combined with some type of socialized health insurance. Unless the government owns the facilities and/or employs providers directly, the providers and the government negotiate payment rates that are then used by all. Canada uses a single-payer system, with each region acting as the single payer. See also the related but differing terms All Payer, Social Insurance, and Socialized Medicine.

Single-Specialty Hospital A hospital that provides services focusing on a single specialty such as cardiac procedures or orthopedics. Physicians often have an equity interest in them.

SIU See Special Investigation Unit.

Skill-Based Routing See Intelligent Call Routing.

SLA See Service-Level Agreement.

Slice Business A large employer group that offers more than one insurer and/or HMO to its employees.

Small Business Health Options Program (SHOP) A type of state health insurance exchange that provides access to health insurance for small businesses as defined in the ACA. Phased out beginning in 2019.

SNP See Special Needs Plan.

SOC See Summary of Benefits Coverage.

Social Health Maintenance Organization (SHMO) A type of demonstration Medicare HMO that went beyond the medical care needs of its membership, to include their social and custodial needs as well. Authorized as demonstration projects under Medicare, SHMOs were always rare and Congress ended the Medicare demonstration project in 2008; though at the time of publication, four legacy SHMOs remain. See also Programs for All-Inclusive Care for the Elderly (PACE).

Social Insurance A form of national financing in which the government provides benefits to all for such things as health care, disability, old age or retirement, long-term care, unemployment, and so forth. It is funded through mandatory taxes on all citizens and residents. An example in the United States is Social Security.

Social Security Administration (SSA) The federal agency that manages eligibility and enrollment for both Social Security and Medicare benefits.

Socialized Medicine A type of social insurance in which the government not only pays for health care as a single payer system, but also owns and operates, or has control over the budgets of, significant portions of the healthcare provider system for example, owning and operating the hospitals, controlling regional funding of all healthcare services, and paying the physicians as a single payer. See also Single Payer and Social Insurance.

Solvency Having sufficient assets to be eligible to transact insurance business and meet liabilities. Insurers and HMOs must not only meet solvency requirements applicable to any going concern but must meet statutory solvency requirements under SAP. See also Statutory Net Worth.

Special Enrollment Period A defined period of time following a life event during which an individual is eligible to apply for coverage or to change coverage outside of an established open enrollment period.

Special Investigation Unit (SIU) A department in a payer organization that investigates possible fraud and abuse.

Special Limitations Clause See Laser or Lasering.

Special Needs Plan (SNP) A type of MA plan that may exclusively enroll, or enroll a disproportionate percentage of, Medicare beneficiaries or dual eligibles with special needs. There are three types of SNPs: D-SNP for dual eligibles; I-SNPs for beneficiaries who are institutionalized in an SNF, ICF or an assisted living facility; and C-SNPs or beneficiaries with one or more severe or disabling chronic conditions.

Special Qualifying Period See Special Enrollment Period.

Specialty Care Physician (SCP) A physician who is not a primary care physician (i.e., a specialist). Occasionally referred to by the acronym "SCP," but that acronym is not used nearly as often as is "PCP."

Specialty Network Manager A single specialist or a specialist organization that manages a single specialty, often under capitation. Specialty services typically are supplied by many different specialty physicians, but the network manager has the responsibility for managing access and cost and is at economic risk. This is a relatively uncommon model.

Specialty Pharmacy Very specialized and very costly drugs that include biopharmaceuticals, meaning injectable drugs created through recombinant DNA; drugs for rare conditions; drugs that require special handling or monitoring; drugs that are available only through limited supply channels; and/or any drug that exceeds some cost threshold such as $500 or $1000 per month to use. See also Compounding Pharmacy.

Specialty Pharmacy Benefits Manager (SPBM) A pharmacy benefits manager that focuses on managing specialty pharmacy benefits. It may be part of a pharmacy benefits manager or a separate company.

Specialty Pharmacy Distributor (SPD) A company that distributes specialty pharmacy products from the manufacturer to the provider and/or directly to the patient, so as to address the unique distribution, storage, and utilization issues around these types of injectable drugs. It may be part of a pharmacy benefits manager or a separate company.

SREs Serious reportable events. See also Never Events.

SSA See Social Security Administration.

Staff Model HMO A closed-panel HMO that employs providers directly, and those providers see members in the HMO's own facilities.

Stark Laws or Stark Regulations See Ethics in Patient Referrals Act.

Stars Program An unofficial name for the Quality Bonus Program (QBP) for MA plans. See also Quality Bonus Program.

State Children's Health Insurance Program (SCHIP or CHIP) A pilot program created by the federal government to provide a "safety net" and preventive-care level of health coverage for children, funded through a combination of federal and state funds, and administered by the states in conformance with federal requirements.

State Insurance Exchanges A means for individuals and small employer groups to access coverage from qualified health plans as provided for in the ACA. In states that either could not or would not create and operate their own exchanges, the federal government did so for them.

State Licensure The insurance license or COA issued by a state to a health plan that allows an insurer or HMO to write business in the state. It may be based on having a license in a different state. See also State of Domicile.

State of Domicile The state in which an insurance company or HMO is licensed as its primary location. For example, a payer may have its state of domicile in Virginia, but also be licensed and doing business in Maryland and the District of Columbia. In many states, the insurance commissioner will defer primary regulation to the insurance department in the state of domicile as long as all of the minimum state standards are met.

Statutory Accounting Principles (SAP) Accounting rules created by the National Association of Insurance Commissioners (NAIC) that focus on the balance sheet and solvency analysis in ways that differ from Generally Accepted Accounting Principles (GAAP). The intent of SAP is to ensure that a risk-bearing entity such as an insurer or HMO has more than enough (relatively) liquid assets beyond expected claims reserves. See also Statutory Net Worth, Nonadmitted Asset, and Risk-Based Capital.

Statutory Net Worth, Statutory or Statutory Capital The total net worth of an insurer or HMO as defined under SAP rules. For purposes of health insurance and managed care, statutory net worth is what a health plan has in cash or in assets that can rapidly be converted into cash in the event of plan failure. States define the minimum statutory net worth that an insurer or HMO must have before it is considered to be financially impaired. See also Nonadmitted Asset and Risk-Based Capital.

Stiftelsen Det Norske Veritas See Det Norske Veritas.

Stop Loss A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis, and may be specific and/or aggregate. Specific coverage applies to individual cases, while aggregate coverage applies to the total costs rather than a specific case. HMOs may also provide a form of stop loss protection to capitated providers, but it is not an actual insurance policy. See also Capitation and Reinsurance.

Subordinated Note Essentially an irrevocable promise from a qualified lender such as a bank that a health plan can borrow money up to the limit of the note if necessary to pay claims, with the holder of the note being repaid only after all claims costs are settled; in other words, repayment of the lender is subordinate to payment of claims. This subordination allows the plan to claim the note for purposes of net worth since it is immediately convertible to cash even though it is not cash-in-hand. A note or loan for which the plan must pay the note holder regardless of the plan's inability to pay claims is not subordinated and cannot be counted as part of its net worth.

Subrogation The contractual right of a health plan to recover payments made to a member for healthcare costs after that member has received such payment for damages in a legal action. Subrogation is illegal in some states but is required in others.

Subscriber The individual or member who has the health plan coverage by virtue of being eligible on his or her own behalf, rather than as a dependent. See also Member.

Summary of Benefits Coverage (SBC or SOC) A brief and easily understandable standardized

four- to six-page document summarizing benefits, requirements, and rights. Under the ACA, payers are required to provide the SBC before enrollment, each time a policy is renewed, and whenever there is a substantial change in the policy.

Surplus The amount of money that an insurer or HMO has that is not earmarked for claims payment. A surplus may be used to boost reserves, to keep rate increases down, or to invest in operational improvements. In nonprofit plans, it equates to retained in a for-profit plan, but it may not be distributed like profits or dividends to shareholders or executives.

Surprise Bills Unexpected bills received by a member for services provided by out-of-network providers in conjunction with an authorized procedure at an in-network facility by in-network physicians. It is most common with hospital-based physicians that a patient has no choice about, and usually doesn't even meet, but it can also happen with a facility charge for an otherwise routine office visit to a physician employed by a hospital.

Suspend What happens when a claim in process cannot be completed due to missing or inconsistent information; it is suspended until manual intervention allows it to be completed. Claims suspensions may also be called edits or pends. As a practical matter, the terms "pend" and "suspend" are often used synonymously, but some payers differentiate between claims that examiners place on hold (pends) and those that are placed on hold automatically by one or more systems edits (suspends).

Sutton's Law "Go where the money is!" the reply attributed to the Depression-era bank robber Willy Sutton, when asked why he robbed banks (it is not clear that he actually said it, but he did say he agreed with it). It is a good law to use when determining what needs attention in a health plan, or any aspect of any business for that matter.

Switch The computer that handles a company's or organization's telephone calling system. A charming holdover from the 19th and early 20th centuries when telephone operators – humans – routed calls by switching connections through a switchboard with plugs and sockets. Even the early automated direct-dial phones were routed through electromechanical switches by routing calls based on the number of paired "clicks" produced each time the phone's dial was rotated. It is why you still "dial" a phone today or if you are in Hollywood, mime a rotary motion with one finger while pointing another finger at your ear as a way of saying "call me," whether sincere or not.

T

Taft-Hartley Plan A Multiple Employer Welfare Benefit Plan operating as a trust under ERISA that is funded by one or more employers and controlled by both the employer(s) and the organized labor union representing their employees. It is typically confined to one type of industry (e.g. Longshoremen, electrical workers, etc.). Also called a Taft-Hartley Trust. Its primary focus is usually on pensions, but it is used for health benefits too. It is eligible to be a type of MA plan. Not to be confused with a Multiple Employer Welfare Association (MEWA) or a Multi-Employer Trust (MET) that do not involve organized labor and that may not be confined to a single type of industry.

TANF See Temporary Assistance to Needy Families.

TAT See Turnaround Time.

Tax Credit The way the federal government provides subsidies to qualified individuals and small groups that purchase coverage through an insurance exchange.

Tax Equity and Fiscal Responsibility Act of 1982 (Pub. Law 97-248) (TEFRA) A federal law that prohibits employers and health plans from requiring full-time employees between the ages of 65 and 69 to use Medicare rather than the group health plan. TEFRA also first enabled federally qualified HMOs to offer plans to Medicare beneficiaries if they met certain other requirements as well.

TCM See Transitional Case Management.

TEFRA See Tax Equity and Fiscal Responsibility Act of 1982.

Temporary Assistance to Needy Families (TANF) A government program that provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs. Medicaid coverage is typically one component of the TANF program.

Third-Party Administrator (TPA) Commonly used to refer to a company that performs administrative functions such as claims processing, membership, UM or other administrative functions for a self-funded plan. TPAs may also perform services for insurers or HMOs in some cases. By convention, the term TPA is used for free-standing administrators, not for full-service payers that provide all or most of the administrative services to self-funded accounts. See also Administrative Services Only (ASO).

Tiering Categorizing coverage into different tiers, or benefits levels. In pharmacy tiering, for example, Tier 1 drugs require lower copayments than to Tier 2 drugs, Tier 3 drugs, and so forth. When it is applied to providers, members accessing Tier 1 providers have less (or even no) cost sharing than if they use a Tier 2 provider. Tiering may be used with hospitals and facilities as well, but they usually resist it strongly.

Time Loss Management The application of managed care techniques to worker's compensation treatments for injuries or illnesses so as to reduce the amount of time lost on the job by the affected employee.

TJC See The Joint Commission.

Total Capitation See Global Capitation.

TPA See Third-Party Administrator.

Transition Management or Transition Case Management (TM or TCM) A program to facilitate the discharge of a patient with complex medical problems or who is otherwise at risk for post-discharge complications and/or an avoidable readmission. TCM programs function much like traditional case management, but focus on the immediate post-discharge period. Also called Care Coordination and Transition Management (CCTM). See also Avoidable Readmission.

Transparency The practice of making data available to the public. Also called pricing transparency when such data consist of the prices for services from different providers of care. Pricing transparency almost always also means posting full prices – such as chargemaster charges – but not negotiated contractual payment terms that are confidential. Transparency is believed by many to have near-magical powers to reduce costs, despite its irrelevance to actual payment terms, the lack of evidence it lowers costs and the likelihood that it does just the opposite.

Treaty A reinsurance agreement between the reinsured company and the reinsurer, usually for one year or longer, which stipulates the technical particulars applicable to the reinsurance of some class or classes of business, usually under a Quota Share Reinsurance; see Quota Share Reinsurance.

Triage In health plans, the process of sorting out requests for services by members into those who need to be seen right away, those who can wait a little while, and those whose problems can be handled with advice over the phone. The origins of this term are grim: The process of sorting out wounded soldiers, sailors, and marines into those who can be saved if treated immediately, those who can wait, and those who are so severely injured they cannot be saved and are given pain relief only.

TRICARE The U.S. Department of Defense's worldwide managed healthcare program. TRICARE was initiated in 1995, integrating healthcare services provided in the direct care system of Military Treatment Facilities (MTFs) with services purchased from civilian providers for anyone eligible for coverage (e.g., retirees and dependents). There are a variety of TRICARE benefits programs. The non-MTF portion of TRICARE is administered by private managed care companies in three regions in the United States, in cooperation with the Uniformed Services commanders responsible for healthcare in each TRICARE region. See also Military Health System.

Triple Option Most common meaning is a POS plan that combines an HMO, a PPO, and indemnity coverage to provide three coverage options to members whenever they seek services. Using the HMO system has little cost-sharing, using the PPO system has a cost-sharing amount typical for PPOs in general, and using providers that do not contract with the plan in any way incurs the most cost-sharing. See also Dual Option.

TrOOP See True-Out-of-Pocket Cost.

True (or Total) Out-of-Pocket Cost (TrOOP) A federal term for expenses that count toward a person's Part D Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin.

Turnaround Time (TAT) The amount of time it takes a health plan to process and pay a claim from the time it arrives.

U

UB-04 See Universal Billing Form 04.

UB-92 Institutional claims form no longer in use and replaced by the CMS-1450 and Universal Billing Form 04 (UB-04).

UCR See Usual, Customary, or Reasonable.

UM See Utilization Management.

Unbundling The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments. Most payers disregard them when possible according to their internal payment guidelines. In most cases, a form of billing abuse.

Uncompensated Care Healthcare services for which the provider receives no direct payment. Considered to be charity care if it is provided even knowing there will be no payment. It is otherwise due to non-payment, in part or in full, and must be written off by the provider. Uncompensated care costs are partly shifted into higher prices charged to payers, absorbed in part by healthcare providers, and are sometimes factored into Medicare and Medicaid payments called Disproportionate Hospital Share (DHS) payments. Under the ACA, DHS payments were reduced for most hospitals under the belief that the amount of uncompensated care would go down, which has happened, though much less so in states that did not expand Medicaid. See also Disproportionate Share.

Underwriting (1) Bearing the risk for something (i.e., a policy is underwritten by an insurance company). (2) The analysis of a group that is done to determine rates and benefits, or to determine whether the group should be offered coverage at all. (3) The old practice of conducting health screening of each individual applicant for insurance and then refusing to provide coverage for people with preexisting conditions, which is now prohibited under the ACA for comprehensive health benefits plans. Still allowed for supplemental plans such as Medicare Supplemental benefits plans.

Underwriting Margin The amount of money from premiums that is left after claims have been paid or accrued, and administrative costs. It does not include any investment income, subsidiaries, or the like. See also Operating Margin.

Universal Billing Form 04 (UB-04) The paper form that institutions must use if they submit a paper claim to Medicare. Its use is also required by commercial payers for paper claims. The UB-04 form replaced the paper UB-92 form from prior years. The more commonly used (and interchangeable) name for this form is CMS-1450.

Universal Provider Identification Number (UPIN) An archaic term referring to the identification number once issued by CMS for use for billing Medicare. The UPIN was replaced by the NPI in 2007. See also National Provider Identifier.

Upcoding The practice of a provider billing for a procedure that pays better than the service actually performed. For example, an office visit for which the maximum allowable charge is $45 may be coded as a complex visit that is paid at $75. A form of billing abuse.

UPIN See Universal Provider Identification Number.

UR See Utilization Review.

URAC A not-for-profit organization that accredits health plans and other types of organizations as well as multiple related functions. Its primary focus is payers, although it has expanded its accreditation activities by, for example, accrediting health-related websites. States often require certification by URAC or another accreditation organization to operate. URAC once stood for Utilization Review Accreditation Commission, and the organization was also once known as the American Accreditation HealthCare Commission (AAHC); neither of those names is used today.

URO See Utilization Review Organization.

Usual, Customary, or Reasonable (UCR) A statistically based method of profiling prevailing fees in an area and paying providers on the basis of that profile. One archaic method was to array all fees for a specific procedures and choose the 80th or 90th percentile as the UCR upper limit. Payers typically

use another method to determine maximum payment amounts. Sometimes this term is used to refer to a fee schedule even if it was calculated using a different approach.

Utilization Management (UM) The combined activities of a payer or integrated delivery system to make medically necessary services available, but to also reduce unnecessary utilization and manage costs. There are three broad areas of utilization review: prospective review, concurrent review, and retrospective review. It may also include some elements of other activities such as case management.

Utilization Review (UR) An older term for utilization management, and somewhat less encompassing of all UM activities. It is still frequently used to refer to precertification of hospital cases alone. See also Utilization Management.

Utilization Review Organization (URO) A free-standing organization that performs utilization review using consistent guidelines and procedures to monitor and determine medical necessity, appropriateness, and comparative cost of health care services and procedures. Usually required to be licensed by states in which it provides services.

V

Value-Based Insurance Benefits Design (VBID, VBBD, or VBD) A benefits design that allows for improved coverage under certain conditions. For example, a member with congestive heart failure would be able to obtain certain drugs without having to pay a copayment or coinsurance.

Value-Based Payment (VBP) Modifications of payments to hospitals by CMS based on several factors such as efficiency, consumer satisfaction, and/or other metrics. VBP is required under the ACA. Can include capitation, P4P, or any type of payment modification that helps to align the incentives of the provider and the payer, employer group, or governmental agency.

Value-Based Payment Modifiers A modifier created under the ACA that affects the overall payment amounts in Medicare FFS, and that is based on how well a physician or medical group scores on its reported quality-related metrics.

VBID, VBD, or VBBD See Value-Based Insurance Benefits Design.

W

Waiting Period The amount of time a new employee must wait before being eligible for coverage under an employer group plan. The ACA limits the waiting period to no more than 90 days.

Waste, Fraud, and Abuse See Fraud, Waste, and Abuse.

Welfare Benefits Plan A type of employer-sponsored employee welfare benefit plan as defined in paragraph 419(e) of the U.S. Internal Revenue Code that can be used for providing employee benefits including life, health, disability, and other similar benefits.

Woodwork Effect An increase in enrollment that can occur after health benefit programs are expanded or changed, encouraging eligible participants to "come out of the woodwork" to enroll in them.

Workgroup for Electronic Data Interchange (WEDI) A group that provides input on electronic transaction standards under HIPAA.

Worker's Compensation A form of insurance that provides for medical benefits and replacement of lost wages that result from injuries or illnesses that arise from the workplace; in turn, the employee cannot sue the employer unless true negligence exists. It is not considered to be health insurance. Worker's compensation has undergone dramatic increases in cost, resulting in carriers adopting managed care approaches. It is often heavily regulated under state laws that are significantly different than those used for group health insurance. See also Time Loss Management.

Wraparound Plan Insurance or health plan coverage for copayments and deductibles that are not covered under a member's base plan. Medicare Supplemental is a form of wraparound. Such options exist for commercial plans as well.

Z

Zero Down The practice of a medical group or the like distributing the entire capital surplus in a health plan (except for the surplus required for statutory reserves) or the group to the members of the group, rather than retaining any capital or reinvesting it in the group or plan. Understandable if short-sighted for excess capital in a medical group; courting disaster if applied to excess capital in a health plan unless the excess is more than triple the required minimum statutory net worth and there are no investments required to update IT, hire employees, or any other costs.

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