

The following is a sample of the outline section of the study manual:

LEARNING OBJECTIVE 1 – SINGLE EMPLOYER GROUP COVERAGES

Rosenbloom chapter 6 – Understanding Managed Care Health Plans: The Managed Care Spectrum

Introduction

1. By 2003, only 5% of covered workers were enrolled in traditional indemnity health plans. Most workers are now enrolled in PPOs, HMOs, and POS plans.
2. This chapter will analyze characteristics of managed care plans

Economic Trends

1. The federal government has tried to stop escalating cost increases by shifting costs to state and local governments and the private sector
2. Competitive global environment
 - a) Government health programs in foreign countries are making it difficult for US companies to compete globally
 - b) Among the top industrialized nations, the US has the highest health cost per capita while having the lowest percentage of government funding for health expenditures (shown in figure 6-1)
3. Shrinking workforce
 - a) Lack of qualified workers makes hiring difficult
 - b) Baby boomers are retiring in large numbers, and these numbers will continue to increase in the next 10 to 15 years
 - c) To make up for the shrinking workforce, employers must offer more competitive (and more costly) packages to attract and maintain qualified workers
4. National resources – the percentage of gross domestic product spent on health care continues to increase
5. Impact on the plan sponsor
 - a) Health care benefit costs rose from about 5% of corporate earnings in the 1960s to between 25% and 50% of earnings in the 1990s
 - b) As a result, a larger portion of the total compensation package must now pay for health care

The Development and Growth of Managed Care

1. History of managed care
 - a) In the strictest sense, the prepaid plans of the 1920s were managed care plans
 - i) HMOs and Blue plans were spin-offs of these plans

- ii) However, prepaid plans did not have provider restrictions or utilization management (UM) programs
 - b) The popularity of HMOs in the late 1970s and 1980s forced insurers to develop either their own HMO plans or new managed care products (such as PPOs)
 - i) Early PPO plans were discounted fee arrangements with no focus on UM
 - ii) These plans had more benefits than a regular HMO, and therefore cost more
 - c) In 1988, point-of-service (POS) plans emerged. These plans are a mix between HMOs and PPOs.
 - d) By 2003, large insurance companies owned 58% of the total HMO enrollment
2. Definition of managed care
- a) Managed care programs influence health care in the following ways:
 - i) Plan design features redirect delivery of medical care
 - ii) Access is restricted to a specific group of providers
 - iii) UM programs preauthorize certain medical care and monitor the use of more expensive forms of care
 - b) There is debate in the industry as to which plans (HMOs, PPOs, POS, and other hybrid plans) are actually managed care plans
 - c) The provider's definition of managed care also differs from the benefit plan's definition
 - i) Providers look at it from the treatment stand point of the insured, not the benefit plan of the insured
 - ii) This could affect what is actually covered as part of the benefit agreement
 - d) The definition itself is not as important as understanding how it is applied
 - e) Managed care companies must develop a plan that works locally. This means they need to:
 - i) Understand the local health care delivery system
 - ii) Develop an appropriate panel of providers
 - iii) Incorporate the necessary managed care mechanisms in the network

Types of Managed Care Plans

- 1. Plan design considerations
 - a) Managed care plans steer members to providers by paying different benefits for in-network and out-of-network providers
 - b) The plan design must be understandable for the insured. Standard plans are used to make things easier for the plan sponsor and its members.
- 2. Managed indemnity
 - a) Managed indemnity is broad and includes most standard fee-for-service plans
 - b) This type of plan usually includes the following:

- i) Precertification of inpatient medical, surgical, and other admissions
 - ii) Precertification of certain outpatient surgical and diagnostic testing
 - iii) Second surgical opinion
 - iv) Case management for high-dollar cases
 - c) The following points should be considered in the plan design
 - i) Deductibles should be increased to keep pace with inflation
 - ii) Coinsurance percentages typically cover expenses at 80% after the deductible
 - iii) Coinsurance limits should adjust with inflation
3. Preferred Provider Organizations (PPOs)
- a) PPOs provide benefits through a network of contracted providers
 - b) A PPO plan can be a side option or stand alone
 - c) These plans allow the insured to use any provider in the network without a prior referral
 - d) The PPO handles all insurance paperwork for the member
 - e) The member can still use a provider outside the network, but it will cost more
 - f) PPO plan designs create incentives to use preferred providers, such as:
 - i) The deductible is lower if preferred providers are used
 - ii) The coinsurance is lower (typically 20% lower) for preferred benefits
 - iii) Coinsurance limits are lower for preferred benefits
 - g) There are three different approaches for designing a PPO plan:
 - i) Incentive approach – this is used when the primary objective is to introduce managed care with the least disruption. Nonpreferred benefits stay at existing levels while preferred benefits are increased.
 - ii) Disincentive approach – this is used when the primary goal is cost savings. Preferred benefits stay at existing levels while nonpreferred benefits are reduced.
 - iii) Combination approach – this is used when the goal is to introduce managed care and save some money. The preferred benefits slightly increase and the nonpreferred benefits slightly decrease.
4. Point-of-service (POS)
- a) POS plans allow more cost control than PPO plans and greater provider choice than HMOs
 - b) The key component is a primary care provider (PCP)
 - i) Preferred benefits are only available for care rendered by or coordinated through the PCP
 - ii) Any other care, even by network providers, is payable at the nonpreferred level
 - c) Plan features typically include:

- i) No deductible and 100% coverage after an office visit copay, for care through the PCP
 - ii) Preventive services when obtained through the PCP
 - iii) One routine gynecological exam per year
 - iv) No member claim submission when the PCP treats or refers the member within the network
 - v) The PCP directs medical care and obtains any necessary precertifications
 - d) POS plans may be designed with the same incentive, disincentive, and combination approaches as are used for PPO plans
5. Health Maintenance Organizations (HMOs)
- a) HMOs provide comprehensive benefits through an established provider network
 - b) No coverage is available outside the network, except for emergencies or when traveling outside the coverage area
 - c) Typical plan features include:
 - i) No annual deductibles and small office visit copays
 - ii) Comprehensive coverage
 - iii) No claim forms to file
 - iv) Preventative care
 - d) There are three basic types of HMOs
 - i) Group model HMOs
 - a. Contracts with groups of physicians
 - b. Links the financial well being of the HMO to the medical group
 - c. Physicians are not employed by the HMO, but have a large number of HMO patients
 - ii) Staff model HMO – like group model HMOs, except physicians are employed by the HMO and are paid a salary
 - iii) IPA model HMOs or “open-panel” plans
 - a. These plans contract with individual practice associations (IPAs) or with private-practice physicians
 - b. Less capital is required
 - c. 67% of HMO plans in the US were IPA HMOs in 1998
6. Comparing managed care plans
- a) The fundamental components in distinguishing between the different types of managed care plans include:
 - i) Degree of freedom in the members’ choice of providers
 - ii) Degree of steering to encourage members to use selected providers
 - iii) Responsibility for claims handling (ie, the member or the provider)

- iv) Degree of external UM controls
 - v) Whether prior referral is required for the member to see a specialist
 - vi) Method of provider reimbursement
 - vii) Whether the patient may be balance billed
 - viii) Rating and financial methods (such as experience rated or community rated)
- b) The managed care spectrum goes from unmanaged (standard indemnity) through managed indemnity, PPO, and POS, up to the most managed plan (HMO). As plans progress through the spectrum, the following occurs (illustrated in Figure 6-9 below and discussed on pages 131-134):
- i) The choice of provider becomes more restricted
 - ii) The degree of steerage increases
 - iii) Claims handling responsibility shifts from the patient to the provider
 - iv) Utilization management increases
 - v) The use of referrals increases
 - vi) Provider reimbursement changes from standard fee-for-service rates to discounted arrangements
 - vii) Balance billing goes from being allowed to not being allowed
 - viii) Rating methods progress from experience rated to community rated
- c) Figure 6-9 from the text (illustrating the managed care spectrum):

Key features	Standard indemnity	Managed indemnity	PPO	POS	HMO
Choice of provider	Unrestricted		Network or non-network	Directed by PCP	Network only
Degree of steerage	None		Moderate	Considerable	Maximum
Claims handling	Patient		Provider in-network Patient non-network		Provider
Utilization management	None	Limited	Moderate	Considerable	Maximum
Referral management	None			PCP must refer all care in network	
Provider reimbursement	Fee for service at R&C levels		Discounted in-network R&C non-network		Discounted
Balance billing	Patient billed for unpaid balance		Network provider accepts fee		No balance billing
Rating methods	Experience rated			Prospectively and exp rated	Community rated

7. Emerging managed care applications

- a) Medicare and Medicaid programs are encouraging managed care options
 - i) Medicare recipients in HMOs must still comply with HMO restrictions, but the HMO benefits are better than standard Medicare benefits

- ii) Members save money by using a managed care option
- iii) In 1982, Arizona was the first state to have managed care for Medicaid members
- iv) 57% of Medicaid recipients were enrolled in some form of managed care in 2003
- b) Studies have shown that the quality of care in Medicaid HMOs is no less than that received under comparable fee-for-service plans
 - i) In 1990, a study showed more immunization and other preventive exams for Medicaid HMO patients than for non-HMO patients
 - ii) Medicare HMO members with cancer were more likely to be diagnosed at an earlier stage than those with fee-for-service plans
- 8. Mental health and substance abuse (MH/SA) benefits
 - a) The least understood Medicaid costs are associated with MH/SA
 - b) There is a lack of uniformity in acceptable treatments
 - c) Payers have difficulty in determining effective alternatives
 - d) The Mental Health Parity Act prohibited lifetime or annual limits for mental health care for most group plans
 - i) Limits can be used if comparable limits also apply to medical and surgical treatments
 - ii) This applies to employers with at least 51 employees that have plans that include mental health benefits
 - e) Some employers have established employee assistance programs (EAPs) and behavioral mental health (BMH) programs to steer care into a managed environment. The types of MH/SA programs are:
 - i) Standard EAP – these programs provide access to professional resources focusing on early intervention and decreased admissions
 - a. These are prepaid arrangements
 - b. Most do not include negotiated pricing at inpatient or outpatient facilities
 - ii) EAP gate plan
 - a. Access to EAP is encouraged through health plan design, thus directing more clients to managed care. For example, maximum MH/SA benefits are only available when the member uses the EAP (except in emergencies).
 - b. These plans are expected to produce greater savings than standard EAP programs
 - iii) MH/SA network – a preferred network of providers is selected based on their clinical expertise and agreement to preferential prices
 - iv) MH/SA network with EAP gate – this approach combines early mental health access with preferred pricing arrangements
 - a. This can be purchased as a stand alone plan or with a medical/surgical plan

- b. This approach is expected to produce the greatest savings
 - f) Between 1993 and 1995, mental health costs increased 9.5% per year under indemnity plans and only 1% per year in network plans
9. Managed disability
- a) Short- and long-term disability plans are good for employees, but expensive for the plan sponsor
 - b) Long-term programs have used rehabilitation and return-to-work programs to reduce some costs
 - c) Most short-term plans are unmanaged
 - d) In the 1990s, insurers started using utilization management for their disability plans
 - i) By managing the short-term disability, they improved the use of long-term disability
 - ii) A team approach is used, involving a nurse consultant, plan sponsor, physician consultants, and vocational and rehabilitation specialists
 - iii) The nurse consultant uses an automated system to determine the expected length of disability, then coordinates everything to ensure good care for the lowest cost
10. Managed workers' compensation
- a) This program provides disability income and medical expense coverage for occupational accidents and illnesses
 - b) This is a state-regulated, no-fault program with prompt compensation for employees, in exchange for not suing their employer
 - c) Medical expenses now account for about 50% of workers' compensation expenses
 - d) Different pilot projects have been authorized in at least 14 states to try to reduce the medical costs of workers' compensation
 - e) Two main managed care models are used for workers' compensation:
 - i) Passive discount PPO model – broad-based PPOs are used to try to ensure workers use a contracted provider. This is the most prevalent, but the least effective model.
 - ii) Proactive model – this model uses the cost-control attributes of an HMO. It is limited to the states that allow employers to tell their employees which providers to use.
 - a. A network of primary care physicians is used to ensure prompt initial treatment
 - b. There is frequent contact between the assigned case manager and the worker
 - c. It is critical for the employer to be promptly informed of any injuries
 - d. This model is being integrated into group managed care packages and is expected to grow quickly

11. Pharmacy benefit management

- a) Trend rates for prescription drug benefits run higher than other types of medical plans
- b) Early HMO plans offered the first flat-dollar copay for prescriptions
- c) In the 1980s, tiered copay levels were introduced to steer patients toward generic drugs
- d) With an explosion of new drugs and many competing brands in the mid-1990s, the pharmacy benefit manager (PBM) concept emerged
 - i) The PBM negotiates with pharmaceutical companies for prices
 - ii) Three-tier plans were created, with separate copays for generic, preferred brand name, and brand name drugs
 - iii) Some plans have gone away from the flat-dollar copay and now have tiered coinsurance payment levels
- e) Plans have also implemented a mail order discount feature – some plans mandate the use of mail order for maintenance drugs (otherwise there is an additional copay for refills)
- f) In addition to plan design mechanisms, PBMs use the following techniques to manage costs:
 - i) Step therapy – members are required to try one drug before another, based on clinically-approved criteria
 - ii) Prior authorization – certain prescriptions must be pre-approved by the PBM
 - iii) Dispensing limits – setting a maximum quantity issued per script or per period of time

Vision Care

1. This type of care, like dental care, is elective and predictable
2. There are three types of vision care professionals
 - a) Ophthalmologists – medical doctors specializing in the total care of the eye
 - b) Optometrists – doctors specializing in the visual system of the eye
 - c) Opticians – they fit, adjust, and dispense eyewear
3. Covered benefits
 - a) Vision examination – this includes a thorough history of general health, vision complaints, and an external and internal examination of the eye. Some plans are exam-only plans and the cost of lenses is the employee's responsibility.
 - b) Lenses – tinted, oversized, and photochromatic lenses are considered cosmetic extras and are usually not covered
 - c) Frames – frames are a necessity, but the cosmetic element can vary the cost of frames dramatically. Plans either limit selection or give a dollar allowance for each year.
4. In plan design, frequency limits (usually 12 or 24 months) are used to keep costs down

5. Schedule-of-benefits approach – this type of plan has a maximum allowance for each service and a frequency limit. A typical schedule pays the lesser of the claimed or scheduled maximum.
6. Preferred Provider Networks
 - a) Employees are steered toward providers that have been negotiated with for services
 - b) There are no forms for the employee
 - c) Providers are solicited by the insurer or administrator
 - d) Most plans still allow reimbursement when a PPO is not used, but the employee must pay the provider's charge and then file a claim for partial reimbursement
7. Vision benefits in flexible benefit plans – the employees are allowed to choose the coverage they desire, but they are limited to the amount of “flex credits” given by their employer
8. Flexible spending accounts (FSAs) – eligible care can be covered under an FSA plan if it is not already covered by a medical or freestanding plan
9. Occupational Safety and Health Administration (OSHA) – eyewear needed for safety in the workplace must be provided by the employer

Hearing Care

1. Coverage
 - a) Surgical procedures affecting the ear are typically covered by standard medical policies
 - b) Some HMOs and other comprehensive plans have added hearing aids to the coverage
 - c) Plans are available that specifically cover hearing care
2. Hearing care benefits
 - a) A common benefit package includes 80% reimbursement with a ceiling of \$300-\$600
 - b) The frequency of benefit is usually 36 months
 - c) Otologic examination, audiometric examination, and hearing instruments are often covered by the plan
 - d) PPOs and FSAs are often utilized for hearing care benefits

The following is a sample from the list section of the study manual.

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Rosenbloom chapter 6 – Understanding Managed Care Health Plans: The Managed Care Spectrum

Ways in which managed care programs influence health care (117)

1. Plan design features redirect delivery of medical care
2. Access is restricted to a specific group of providers
3. Utilization management programs preauthorize certain medical care and monitor the use of more expensive forms of care

Types of managed care plans (119)

1. Managed indemnity – includes precertification of most inpatient and outpatient services, and case management for high-dollar cases
2. PPO – provides benefits through a network of contracted providers, but allows care outside the network at higher deductibles and coinsurance
3. POS – preferred benefits are only available for care rendered by or coordinated through the PCP. All other care is payable at the nonpreferred level
4. HMO – provides comprehensive benefits through an established provider network. No coverage is available outside the network, except for emergencies or when traveling outside the coverage area

Approaches for designing a PPO plan (122)

1. Incentive approach – used to introduce managed care with the least disruption. Nonpreferred benefits stay at existing levels while preferred benefits are increased.
2. Disincentive approach – used when the primary goal is cost savings. Preferred benefits stay at existing levels while nonpreferred benefits are reduced.
3. Combination approach – preferred benefits slightly increase and nonpreferred benefits slightly decrease

Basic types of HMOs (127)

1. Group model HMOs – physicians are not employed by the HMO, but have a large number of HMO patients
2. Staff model HMO – physicians are employed by the HMO and are paid a salary
3. IPA model HMOs (“open-panel” plans) – these plans contract with individual practice associations (IPAs) or with private-practice physicians

Key features of indemnity plans and managed care alternatives (130)
(also referred to as the managed care spectrum)

Key features	Standard indemnity	Managed indemnity	PPO	POS	HMO
Choice of provider	Unrestricted		Network or non-network	Directed by PCP	Network only
Degree of steerage	None		Moderate	Considerable	Maximum
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Utilization management	None	Limited	Moderate	Considerable	Maximum
Referral management	None			PCP must refer all care in network	
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Balance billing	Patient billed for unpaid balance		Network provider accepts fee		No balance billing
Rating methods	Experience rated			Prospectively and exp rated	Community rated

Types of mental health / substance abuse (MH/SA) programs (138)

1. Standard employee assistance program (EAP) – provide access to professional resources focusing on early intervention and decreased admissions
2. EAP gate plan – access to EAP is encouraged through health plan design, thus directing more clients to managed care
3. MH/SA network – a preferred network of providers is selected based on their clinical expertise and agreement to preferential prices
4. MH/SA network with EAP gate – this approach combines early mental health access with preferred pricing arrangements

Managed care models used for workers' compensation (142)

1. Passive discount PPO model – broad-based PPOs are used to try to ensure workers use a contracted provider. This is the most prevalent, but the least effective model.
2. Proactive model – uses the cost-control attributes of an HMO. It is limited to the states that allow employers to tell their employees which providers to use.

Techniques used by pharmacy benefit managers (PBMs) to manage costs (146)

1. Plan design – for example, encouraging usage of generic drugs through lower copays
2. Step therapy – members are required to try one drug before another, based on clinically-approved criteria
3. Prior authorization – certain prescriptions must be pre-approved by the PBM
4. Dispensing limits – setting a maximum quantity issued per script or per period of time