1 The Evolution of Health Plans

Objectives

After completing this module, you will be able to:

- define “managed care” and “health plan,”
- identify three key factors in the evolution of health plans,
- discuss how health plans have responded to the problems of high healthcare costs and reduced access to health coverage, and
- list some of the components included in today’s definition of quality in health plans.

You have no doubt heard the terms “health plan,” “managed care,” and perhaps also “healthcare management.” They are used in various ways, but in general they denote systems that integrate the delivery and financing of healthcare, various techniques used to manage the delivery and financing of healthcare, and organizations that employ these techniques. For the purposes of this course, we will define managed care (healthcare management) as the integration of the delivery and financing of healthcare within a system, plan, or organization that seeks to manage healthcare costs, access, and quality. Such a system, plan, or organization is referred to as a health plan, also called a managed care plan or managed care organization (MCO).

What exactly does it mean to “integrate the delivery and financing of healthcare”? And how does a health plan manage healthcare costs, access, and quality? We answer these questions and many others in this course. We begin in this first module with an overview of how health plans have developed and the factors that affect their continued evolution. Note that in this first module we introduce a number of terms and concepts that may not be familiar to you—they will be explained in detail in the modules that follow.
An Important Note on the Affordable Care Act (ACA)

In March 2010 Congress enacted the Patient Protection and Affordable Care Act (PPACA), more commonly called the Affordable Care Act (ACA) or simply referred to as healthcare reform. This legislation brings about major changes in our country’s healthcare financing system, including health plans, and we address it in this course:

- In course modules, as we cover various aspects of health plans, we discuss provisions of ACA that will have an impact in those areas.

- Near the end of the course, we offer an overview of ACA, explaining in broad terms how it will change the healthcare system and its impact on health plans.

We emphasize two points:

- The discussion of ACA in this course is not comprehensive. We briefly describe in general terms the main components of this very complex and lengthy legislation, with a focus on the elements that affect health plans. We do not cover all of the provisions of the legislation, which is hundreds of pages long, and for the provisions that we do address, we do not include all details and exceptions.

- The new system and rules are evolving. Many details and important matters still remain to be decided as the law is interpreted, clarified, and implemented over the next few years. This module is based on what is known in late 2010. Students are encouraged to visit our website (www.ahip.org) for developments.
The Development of Health Plans

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

- 1910. The earliest examples of health plans appeared in the form of prepaid group practices. These were healthcare systems in which plan members paid a monthly premium and in return received a wide range of medical services through an exclusive group of providers.

- 1929. Blue Cross plans providing prepaid hospital care were established.

- 1930. Blue Shield plans providing reimbursement for physician services were established.

- 1954. Individual practice associations (IPAs), which contracted with physicians in independent fee-for-service practices, emerged as a competitive response to health maintenance organizations (HMOs), which were based on group practices.

For many years health plans accounted for only a small fraction of all health coverage. But in recent decades they have grown dramatically, and they now cover a large portion of the U.S. population. There have been many reasons for this growth, but we will focus on three key factors: the HMO Act of 1973, consumer and employer demand, and government involvement.

The HMO Act of 1973

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

- **Federal qualification.** HMOs were given the option of becoming federally qualified. To do so, they had to meet a number of standards related to minimum benefit packages, provider network adequacy, enrollee grievance systems, financial stability, and quality assurance.

- **Dual choice.** Employers that offered indemnity health insurance to more than 25 employees had to also offer a federally qualified HMO (if an HMO requested it).

- **Federal funding.** To encourage their development, grants and loans were made available to federally qualified HMOs. Funding could be used to expand the service area of an existing HMO or establish a new HMO.

- **State law exemption.** Federally qualified HMOs were exempted from state laws that restricted their development.
Although federal qualification was optional, many HMOs sought it because of the advantages mentioned above and because it could be cited as a “stamp of approval” in marketing. But on the other hand, in some ways it weakened the competitive position of qualified HMOs, since they had to meet the federal standards and traditional indemnity insurance or other health plans did not.

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

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

**Consumer and Employer Demand**

HMOs had significant success in containing healthcare costs and holding down premium increases, and by the early 1990s consumers and employers sponsoring health coverage had come to embrace them. But a traditional HMO required members to receive healthcare only from providers affiliated with the plan (that is, in the plan’s network), and consumers became dissatisfied with this restriction. They wanted the lower cost of an HMO but more leeway in choosing providers. New health plan types were developed to address this demand. Two of the most important were PPOs and POS products.

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

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

Consumers also wanted coverage of specialty healthcare, such as dental care, vision care, behavioral health, and prescription drugs, and employers wanted more cost-effective ways of providing such benefits. In response, health plans developed **specialty “carve-out”** plans and products with specialized provider networks. Specialty coverage may be integrated into a comprehensive health plan or offered as stand-alone product.

Around the beginning of the new century, health premiums began to go up again, and consumers and employers looked for new solutions. One approach is **consumer-directed health plans (CDHPs)**. CDHPs are based on employer funding of a core set of benefits, employee financial responsibility, and increased accountability of the health plan and providers. Under a CDHP, the individual has both a health insurance plan with
a high annual deductible and a tax-advantaged health savings account. He or she uses money from the account to pay for healthcare expenses before the high deductible of the health plan is satisfied, as well as other out-of-pocket healthcare costs, generally on a tax-free basis. This approach both makes possible a low premium and gives consumers an incentive to make prudent healthcare choices, as they pay much of the cost themselves.

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

**Government Involvement**

Government has long been involved in health insurance, at both the state and federal levels. For over a century, states have regulated insurance companies, including health insurers. They mandate or prohibit certain policy provisions, impose financial requirements, oversee sales and marketing, and enforce many other rules. The federal government has historically taken a secondary role, but it does enact legislation that affects insurers and health plans. As we saw, in 1973 Congress enacted the HMO Act. In 1996 it passed the Health Insurance Portability and Accountability Act (HIPAA), which included a wide variety of requirements for health plans. And most recently, in March 2010, the Affordable Care Act (ACA), commonly referred to as healthcare reform, was enacted. This legislation will have a major impact on healthcare and health plans in the years to come.

The government plays another important role in health plans—it is a major purchaser of health coverage, financing healthcare for millions of Americans through several programs. In 1965 the Medicare program for the elderly and disabled and Medicaid for the poor were established, followed in 1997 by the Children’s Health Insurance Program (CHIP). And the federal and state governments have long sponsored health coverage for millions of government employees and members of the military and their families. Government health coverage programs have helped drive the growth of health plans by increasingly turning to them as alternatives to traditional indemnity insurance. By 2010 approximately 11.1 million Medicare beneficiaries (24 percent) were enrolled in a Medicare Advantage health plan,¹ and about 70 percent of Medicaid enrollees received some or all of their healthcare through managed care.²

**Current Factors in the Evolution of Health Plans**

Now let’s turn our attention to current trends. The most important is the steady rise in healthcare costs. This has made it necessary for health insurance premiums to be increased, and that in turn has made it harder for employers and consumers to afford coverage. Health plans have responded to these problems with a number of solutions.

**Rising Healthcare Costs**

Spending on healthcare in the United States has been rising for many years, surpassing $2.3 trillion in 2008. This is more than three times the $714 billion spent in 1990 and about nine times the $253 billion spent in 1980. In 2008 U.S. healthcare spending was about $7,681 per resident and accounted for 16.2 percent of the nation’s Gross Domestic Product.³ What is driving this increase? Let’s look at some key factors.
Technological and Pharmacological Advances

New tests and treatments involving technology are constantly being developed, and new drugs are being invented. These advances have enabled doctors to prevent, cure, or manage a variety of medical conditions, allowing many people who just a few years ago might have died or lived with pain or severe limitations to live normal lives. But in many cases they are extremely expensive, and this has been a major component of cost increases.

Demographic Changes

The percentage of the U.S. population 65 or older continues to rise dramatically, and of course older people need more medical care than younger people. They frequently have chronic diseases that require ongoing treatment, medication, and therapy, and they often need nursing home care or home healthcare. And a very substantial portion of healthcare spending goes to people in their last few months of life, when long hospital stays (often in intensive care), multiple operations, and the use of technology are common.

This increase in the elderly population will only accelerate with the aging of the Baby Boom generation, those born in the two decades after World War II. Birth rates were high in those years, so there are considerably more people in this age group than in younger or older generations. These people are now in late middle age, and in the next few years the oldest of them will begin to turn 65, creating a bulge in the elderly population and an increase in the need for medical care.

Overutilization and Incentives

Another major cause of high healthcare spending is unnecessary medical services. Many physicians, hospitals, and other healthcare providers are still compensated under the fee-for-service approach. This means that the more services they deliver, the more they get paid—in other words, in most situations they have a strong financial incentive to provide additional services, even when it is doubtful that these services are needed or useful. This problem is exacerbated by the fear of malpractice suits, which drives providers to order unnecessary tests and treatments just to make sure no one can accuse them of not doing everything conceivably possible. This is known as defensive medicine.

Other Factors

Commentators have pointed out a few other trends that contribute to higher healthcare spending. More Americans are overweight and physically inactive than in the past, leading to diseases such as diabetes and heart disease and to overall poor health. Some believe that widespread advertising of prescription drugs is creating an inflated demand for some products.

The Uninsured

As mentioned above, to cover greater healthcare costs health plans are forced to raise premiums—otherwise they would go out of business. This has made health coverage less affordable, both for employers and individuals. Businesses have had to stop sponsoring
coverage or shift a larger share of the premium to employees. As a result, many people of modest means cannot afford health coverage. These people often wait until a medical condition becomes severe and then seek care in a hospital emergency room, and they do not receive ongoing treatment or screening for diseases. This drives healthcare costs even higher.

**The Response of Health Plans**

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

- **Provider compensation.** Managed care generally seeks to replace fee-for-service compensation, which as we have seen gives healthcare providers incentives to deliver more services than may be necessary. Health plans use capitation and other compensation methods under which providers have incentives to avoid excessive services. Health plans are also able to negotiate lower payments to providers in exchange for supplying them with a large volume of patients. In this course we will study in detail health plan compensation of providers.

- **Management techniques.** Health plans use a number of approaches to ensure that plan members are cared for in the most effective and cost-efficient way. Health plans emphasize preventing illnesses (much less costly than treating them). Utilization management is employed to ensure that the services patients receive are appropriate to their needs. Case management coordinates care to avoid overlapping services from different providers. Disease management helps patients with chronic conditions maintain their health and avoid serious episodes.

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

- **Technology.** A high priority of health plans is to reduce administrative costs in order to hold down premiums. One of the best ways of doing so is using technology to perform such functions as processing and paying claims, billing, enrolling new members, generating member identification cards, and maintaining information. Handling these operations electronically rather than manually lowers costs by reducing staffing requirements and improves quality and customer service by increasing accuracy and shortening processing time. Health plans are now expanding their use of automation into areas beyond core functions—for example, electronic medical records.

**Quality**

So far we have talked mostly about costs. But another important element in the evolution of health plans is quality. In the past quality was often narrowly measured in terms of the scope of services provided for a certain cost. Today quality is evaluated more broadly and
includes such components as desired outcomes, preventive care, access to physicians (both primary and specialty care), patient satisfaction, and care for chronic illnesses.

*The Role of Employers*

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

*The Role of Accreditation*

Health plans have responded to the demand for quality by establishing quality management programs. They have also sought to demonstrate the quality of their operations to consumers, employers, and government agencies by obtaining accreditation from independent agencies. Two of the best known accrediting bodies are NCQA and URAC.

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

- **URAC** (formerly the Utilization Review Accreditation Commission, now simply URAC) was originally formed to evaluate utilization review processes, but it has expanded into evaluating health plans and other healthcare entities. The stated mission of URAC is “to promote continuous improvements in the quality and efficiency of healthcare management through processes of accreditation and education.”

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

**Notes**


4 NCQA. www.ncqa.org.
5 URAC. www.urac.org.