3 Health Plan Benefits and Networks

Objectives

After completing this module, you will be able to:

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

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

Health Plans

We noted previously that the term health plan has many meanings. You will recall that we defined a health plan as the integration of the financing and the delivery of healthcare within a system that seeks to manage the cost, access, and quality of care. For this reason health plans may also be called managed care plans or managed care organizations. The term “health plan” may be used to refer to a single organization or to a company that offers several types of health insurance or health plan products. In this course, we will use the term “health plan” to refer to any entity that utilizes certain concepts or techniques to manage the cost, access, and quality of healthcare.

Just as it is difficult to define a health plan, it is an equally complex task to describe and distinguish among the different types of health plans and health plan products. In some cases, the same term may be used to describe both a type of health plan and a type of health plan product. Examples of health plan types are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and physician-hospital organizations (PHOs).

Health Plan Products

In an effort to meet changing customer demand for customization and flexibility of product options, health plans are offering more and different health plan product types and models. In general, there are some basic characteristics that distinguish the different types of products from one another. But product types are becoming less clearly distinguishable from one another, and there few rigid and absolute distinctions among different types. And it is likely that these distinctions will blur even further as the health plan industry continues to evolve.
Examples of types of health plan products:

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

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

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

**Managed Care Techniques**

Health plan products vary in their use of managed care techniques, with a range from highly managed to minimally managed products. The cost-containment techniques described earlier are examples of some ways that health plans manage costs. Other managed care techniques include benefit design and cost-sharing structures, network structure, and various medical management practices (such as prior authorization, second opinions, and case management programs). Figure 3.1 illustrates the managed care continuum.

**Figure 3.1**
**The Managed Care Continuum**

<table>
<thead>
<tr>
<th>Less</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional indemnity health plans</td>
<td>Traditional with cost-containment features</td>
</tr>
</tbody>
</table>

All health plan products can be positioned between the two ends of the continuum. The farther to the right on the continuum a health plan is (for instance, an HMO), the more managed care techniques and concepts are practiced by the plan. As you learn more about the different types of plan products, you will begin to understand where each type of plan fits on the continuum.
Regardless of where a plan product falls on the managed care continuum, all health plans have in common the ultimate goal of accessible, cost-effective, and quality healthcare.

The Key Players

There are key participants in health plans. These are organizations and individuals who are involved in the delivery, financing, and consumption of healthcare. The roles of these participants evolve as health plans mature and new types of health plan products are introduced. The key players in health plans include:

- **Providers**—individuals and entities that provide healthcare services, such as physicians, nurses, hospitals, and laboratories.

- **Payors**—organizations or individuals that finance or reimburse the cost of healthcare services, such as insurance companies, health plans, and the federal government.

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

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

In health plans, services are delivered through integrated systems of providers and the plans, with all of the key players working together. As we mentioned previously, the roles of these players are changing—roles have begun to overlap, and there are fewer distinctions between the roles of key players. For example, risk bearing (assuming the financial risks associated with the costs of care provided to members) has generally been associated with the payors, such as Medicare and Medicaid and insurance companies. But in coordinated healthcare delivery systems, providers share the role of “risk bearers.” The evolution of roles will certainly continue as health plans and products evolve.

Health Plan Benefits

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

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

The following are some services and terms typically found in plan benefits:

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

• **Specialty care (secondary care)**—medical care delivered by a specialist, including outpatient and inpatient services provided by acute care hospitals.

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

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

• **Outpatient services**—services provided by a hospital or other healthcare facility without the patient staying overnight.

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

**Preventive Care**

Health plans focus on improving the health of their members and typically place greater emphasis on preventive care than do indemnity plans. Examples of preventive care services include physical examinations, immunizations, well child care, and routine mammograms. Plans use benefit design to encourage members to utilize preventive care services and to seek care earlier. For example, typically in health plans members pay nothing or very little for preventive services, thereby removing financial barriers to their use.

**Mandated Benefits**

In some cases federal or state laws require that certain services be included in health plan benefits. These are known as **mandated benefits**. In 1965 there were only seven state-mandated benefits, but today most states have them. Before 1996 only state legislatures had established health insurance mandates, and these mandates applied only to traditional health insurance benefits within the state. But that year Congress passed the first-ever federal benefit mandates, requiring health plans and employers to
cover a minimum maternity stay of 48 hours and to cover mental health services at the same level as physical healthcare services. We will discuss federal and state regulation in more detail later in the course.

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

Cost-Sharing

We introduced deductibles, coinsurance, and copayments in the last module. Let’s take another look.
Copayments

A copayment is a specific dollar amount that a member must pay to the provider out of her own pocket for a specified service at the time that the service is rendered. The amount is the same regardless of the actual cost of care provided. For instance, if a plan has a $10 copayment for a physician office visit, the member pays this amount whether the doctor provides only a few services or many during the visit.

Copayment amounts generally vary by type of service. For example, preventive services may be fully covered by the plan with no copayment, while other services typically require copayments.

Coninsurance

The terms “copayment” and “coinsurance” are sometimes confused, but they have distinct meanings. While a copayment is normally a flat dollar amount (such as $50 per specialist visit), coinsurance is typically a percentage of the total cost of the service or product provided (such as 10 percent of the cost of a $700 test). Thus coinsurance is based on the total cost of the service while a copayment is not.

Deductibles

A deductible is a fixed dollar amount that an insured or member must pay for her healthcare, within some defined period, before the insurer or plan starts to pay benefits. For instance, an insured might have to pay the first $500 of her healthcare expenses each year before the plan begins paying benefits. There may be separate deductibles for specific services, and deductibles may vary depending on whether services are provided by a network or a non-network provider.

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

Access to Care

Now that we have described the types of benefits found frequently in health plans, let’s learn how plan members access these benefits. Previously we defined “access” as an individual’s ability to obtain healthcare. The lack of access to care by many people was one of the main reasons for the recent healthcare reform in the United States.

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

Networks

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

A health plan’s network is formed by the plan entering into contractual arrangements with specified providers. These contracted providers agree to furnish services to specified persons (members or enrollees) in exchange for specified payments. The contract between the plan and the provider also includes rules and obligations, including medical management, billing, etc. There are many variations to the contract, as different arrangements are needed for different types of health plans, products, and networks.

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

- the **right number** of providers,
- the **right types** of providers, and
- providers in the **right locations**.

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

A health plan must validate that providers in its network meet standards for their particular profession. To accomplish this, health plans use various criteria, standards, and processes. These processes and other activities related to provider selection will be discussed in detail in the modules “Health Plan Structure and Management” and “Network Structure and Management.”

**Primary Care**

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

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

In addition to providing primary care services, in many health plans the PCP serves as the member’s point of entry into the healthcare system, her first point of contact. The PCP also coordinates the healthcare services of her members, including determining when specialty care is needed and referring the member to a specialist provider. Other
PCP roles may include managing and directing the member’s healthcare. PCP roles and responsibilities may be defined in the contract between the PCP and the health plan. The role of the PCP may vary depending on the health plan and product type.

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

Provider Choice

A choice of providers is very important when individuals select a health plan and in member satisfaction with their plan. For this reason plans strive to make their networks attractive and comprehensive. In addition, many health plans offer products that allow for more open access and fewer restrictions. PPOs and POS products are examples of products with more open access to providers.

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

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

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

Enhancing Accessibility of Care

By their very design health plans enhance the accessibility of healthcare in ways that are not achievable under indemnity coverage. For instance, a plan’s cost structure may lower members out-of-pocket cost, and there is typically an emphasis on prevention and wellness.

Cost Structure

Traditional indemnity plans typically have high out-of-pocket costs, including significant deductibles and coinsurance, and this may create barriers to access to care. Health plans’ out-of-pocket costs are typically lower, so that care is more accessible.

Primary Care, Prevention, and Wellness

Health plans emphasize primary care, prevention, and wellness. Members are encouraged by benefit design to seek preventive healthcare such as mammograms, physical examinations, and screenings (for instance, for high cholesterol). Health plan primary care focuses on early detection and treatment, preventing illnesses or complications. Health plan benefit designs generally include incentives (such as lower copayments) for members to use PCP services. Some health plans give premium
discounts or include benefit coverage for wellness programs, initiatives, and/or wellness results.

**Utilization and Quality Management**

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

**Utilization Management**

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

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

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

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

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

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

**Quality Management**

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

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

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

- **Measuring and improving care.** Plans measure the quality of the care provided by their providers and seek to improve it in various ways, including outcomes studies, provider profiling, clinical practice guidelines, benchmarking, peer review, and member surveys.
• **Members’ rights and complaint resolution procedures.** Most health plans have a written policy stipulating members’ rights and responsibilities and a formal system for addressing complaints.