

BASIC PRIVATE HEALTH INSURANCE

How managed care works

Commercial health plans are sold as a contract. Health plans agree to provide health services either on an individual basis or to a group of employees. Most individuals are covered through employer-based group health insurance. Health insurance is a contract which must meet certain guidelines under state regulations. These guidelines are enforced through a state government agency.

Group Health Coverage

Group health insurance is most often provided through an employer. Health plans usually receive a set amount of money from the employer to cover their employees' health costs. The employer usually pays on a per employee, per month basis. This is called "capitation." That money needs to cover all the health care costs of all employees covered under the plan for that month. Not everyone goes to the doctor every month. The health plan hopes that there will be more members who stay well during the month. Then the health plan can pocket the money (if it's a for-profit health plan; or reinvest it in health services if it is a non-profit health plan).

The costs to individual members of these plans are usually lower because the insurance company can spread the amount of risk with a larger pool of those covered. "Risk" refers to the responsibility to pay for the actual cost of providing health services. In managed care, usually it's the health plan who assumes the most risk.

Small employers have continually been cutting back on coverage for their employees. They have smaller risk pools to offer health plans. Small employers usually have to pay a higher capitation rate for their employees to receive the same benefits. These small employers have several choices to make when providing health coverage. They may choose to offer a plan but not provide any assistance in paying for the coverage. They may offer only employee coverage leaving dependent/family coverage up to the individual employee to purchase. They may restrict the amount of coverage offered. Co-payments, deductibles and premiums are often high for this employer group.

Large employers (those with 50 or more employees) can often provide a better coverage package with less out-of-pocket costs for employees. Over the last several years even large employers have struggled with keeping costs at a minimum. Some have even chosen to exclude dependent coverage.

Employers have turned to managed care to attempt to keep costs reasonable. They have begun to offer "cafeteria" plans which allow employees to choose the types of benefits they need. The co-pays and deductibles often vary among these cafeteria type plans. Traditional fee-for-service plans under group employment are becoming less and less frequent even under group-based health insurance. Most employers are reaching out to managed care to try to keep their employee costs at a minimum.

Individual Coverage

When a person has no access to a group health plan, health insurance purchased directly from the health plan (rather than through an employer) is usually available. Essentially, the individual must pay the capitation rate that an employer would pay under group health arrangements. Individual coverage is tailored to one person or family and the health plan usually charges a high premium. In addition, there may be high co-payments and deductibles. Often these forms of "cost-sharing" exceeds thousands of dollars. Insurers use these costs both to cut their own expenses, but also in the hope that it will discourage members from using only the most necessary health services. This route to health insurance is usually riddled with higher costs and fewer benefits for the health plan member.

Anyone who has to contact their insurance company before entry into a hospital setting is essentially enrolled in a managed care plan. However, there are three main types of managed health care plans. (See page 23 in FLG for descriptions).

Health Maintenance Organization (HMO)

An HMO is a type of managed care plan that provides or arranges for coverage of defined health services needed by plan members for a prepaid premium. Covered services are usually paid for in full through the premium payment or may require a small fixed fee or co-payment for office visits or other benefits, such as prescription drugs. Plan enrollees must use providers in the HMO network or else services may not be covered. There are several different models of HMO plans.

Preferred Provider Organization (PPO)

A PPO is managed care in which providers in a plan's network receive payments in a discounted-fee arrangement and agree to provide discounted rates. Enrollees are given financial incentives (usually lower deductibles and co-insurance) to obtain care through participating providers. Plan enrollees may seek care through nonparticipating providers, but must pay a higher co-payment.

Point of Service Plan (POS)

POS plans (sometimes called open-ended HMOs) permit enrollees to decide at the time services are needed whether to obtain covered services through designated network providers or through non-participating (out-of-network) providers. Enrollees' cost-sharing responsibilities vary, depending on whether they obtain services through in-network or out-of-network providers. If using in-network services, the HMO's cost-sharing requirements apply. However, enrollees may seek out-of-network treatment and receive benefits on a fee-for-service basis, usually at higher cost to the enrollee.



A Patient Bill of Rights describing the responsibility of managed care plans to group coverage plans has moved slowly through Congress. But several other federal laws are in place that dictate health plan and employer responsibilities. In addition, state laws are enforced by a state insurance commission working closely with the Governor and employers in the state to ensure that health contracts are handled fairly. The state insurance commission also handles any grievances brought about in a dispute between insurance contract partners.