Dear Policy Leader:

The American Association of Preferred Provider Organizations (AAPPO) is pleased to bring you this primer on the health insurance industry, with a particular look at preferred provider organizations. AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. We believe that PPOs offer greater access, choice and flexibility to American health care. PPOs are part of a market-based solution to our health care problems.

AAPPO was established in 1983 to advance awareness of the benefits of PPOs. Since its inception, AAPPO has been the only association advocating solely on behalf of PPOs and continues to lead the way in the promotion, support and advocacy of the PPO industry. AAPPO is constantly working to serve as a resource for its members and policymakers on issues surrounding the PPO industry. AAPPO facilitates initiatives to support the business needs of all PPOs and releases an assortment of information on many important topics impacting the PPO industry.

PPOs work in collaboration with the medical community, respecting the sanctity of the doctor-patient relationship. Currently, more than 204 million individuals are enrolled in a PPO program, which translates to (means) 69 percent of Americans with health care coverage receive their health care services through a PPO delivery system. The fact that PPOs offer exactly what the public has called for — choice, flexibility and a balance between the delivery of appropriate care and cost control — is the primary reason for this growth.

Greater choice, access and flexibility — PPO hallmarks continue to drive the popularity of PPOs in today’s market as more Americans seek to take a more active role in their health care. For example, Health Savings Accounts (HSAs) are an important option for employers and consumers looking for a more affordable health care alternative. PPO networks are the primary delivery system for HSA products. They provide access to quality providers to meet the demands of consumers while strengthening the value proposition of health insurance coverage.

We encourage you to review this document to learn more about how the health insurance industry works. If you have any questions at all, please contact me at (502) 403-1122.

Sincerely,

Karen Greenrose
President and CEO

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Introduction

This Primer provides a very basic overview of the very complex health care and health insurance industry. As this Primer is being written, the Patient Protection and Affordable Care Act (PPACA) is being phased in, even as repeal efforts move forward. The Primer does not attempt to cover the massively complex regulations that will come into effect over the coming years – rather it lays out the framework under which the insurance industry operates and some of the key strategies used to deliver efficient and cost effective services.

1.0 What is Health Insurance?

Insurance of any type – auto, homeowners, and health, for example - is based on the concept that at some point in time, individuals may experience high costs that are beyond their means to pay. Through insurance, individuals pool their funds through “premiums,” to cover potential “losses,” e.g. the need for a payment.

When and if an individual has a loss such as a car accident, health care crisis or home damage, insurance covers that cost. The insurance company runs the risk of losing money if losses are high or premiums are set too low. Thus, insurance is about the transfer of financial risk from an individual to an organization that has experience and financial reserves to manage the risk.

Risk pooling allows the insurance company to combine risk of financial loss across a large population of insured individuals. Typically, only a small number of people become seriously ill and need expensive care in a given year. The company pools the premiums (the periodic payments for the insurance) of the thousands of people it insures to pay the covered bills of those who get sick and need care. The insuring organization establishes premiums using predictions of its future costs. A financially sound insurance arrangement must include healthy as well sick people in order to spread the risk.

Insurance companies handle the functions of pooling funds and paying out “claims” when covered individuals have expenses. Insurance companies also take on the “risk” of potentially incurring losses if their payout is higher than their premiums. To guard against bankruptcy, insurance companies establish reserves calculated to cover any foreseeable losses. The costs of reserves, insurance administration, and if applicable, profits, are included in premiums.

Currently, most health insurance plans in the US pay for the cost of health care services received from doctors, hospitals, laboratories and pharmacies. For instance, in many parts of the country, it is expected that about 22 women of every 1,000 people with insurance will have a baby. Thus, if this is a covered service, the insurance company will establish a premium so that it can afford to pay most of the $5,000 it costs to have a baby. This includes paying doctors, hospitals, laboratories, pharmacies and other providers of services to the mother and new baby.

1.1 About Financial Risk

As described earlier, in the U.S., insurance companies charge premiums and assume the financial risk of health care costs; they are thus the entities are responsible for paying health care bills of insured members. Insurance companies charge premiums and that reflect the financial risk of health care costs. If costs are greater than assumed in developing the premium rates, the insurance company can suffer a
loss. Conversely, if the premium rates provide more money than is actually needed to pay claims, the insurance company will experience profits that are higher than anticipated.

**Underwriting** is the method insurance companies use to analyze the probability of incurring insurance losses for an individual or group. The factors considered in underwriting are average age, gender mix, industry, history of chronic disease, and other factors likely to influence the probability of using medical services. The insurance premium is established based on the underwriting results, which reflect the risk of loss. Higher risk translates to higher premiums.

Insurance companies rely on **actuarial projections** to determine how much money they need on hand to pay medical bills and cover other expenses. Actuaries are professionals who use statistical models to examine the financial risks of health care and the uncertainty of knowing what costs may be incurred. Actuaries develop financial projections related to income and losses to ensure that insurance companies have enough cash and reserves to cover expenses. State insurance agencies typically have actuarial soundness requirements to ensure insurance companies do not come up short in paying the medical bills for insured patients.

Many insurance companies and self-funded employers "re-insure" their business by purchasing **stop loss** or **catastrophic coverage**. This insurance coverage begins if the claims costs for a specific case exceed a specified amount. Stop loss coverage protects the insurer or self-funded employer in rare but extremely expensive cases by capping **financial exposure** at a fixed amount.
1.2 Insurance Markets

Health insurance companies typically sell insurance products according to the size of the group covered by the insurance policy. Actuaries are able to predict differences in use of services and health care needs in different market segments. In general, the larger the group, the more simple it is for the insurance company to predict the risk of losses. Non-governmental programs are called the commercial market. Commercial markets commonly defined by insurance companies include small group, individual, medium, and large group. As discussed in Chapter 2, larger employers find it more advantageous to self-insure.

In any insurance market where purchasing insurance is optional to the employee, it is much more common for the sicker people or those at risk to buy insurance. This can cause the premium to rise as the insurance company predicts that the group will incur higher costs. Increased prices may cause more of the healthier people to drop out, causing another price increase by the insurance company. This price spiral is one reason insurance costs in the small group and individual markets are higher.

In small groups, it is harder to spread the risk. The possibility that one individual will have high costs is relatively high, and there is not a cushion of many pooled premium dollars as there is in a large group. Fewer insurance companies are willing to take the risks of small group and individual markets. Participants purchase and drop coverage more frequently in these markets as well, making the products more expensive to administer.

Under health care reform, these two groups will be pooled and will be eligible to buy insurance through the newly created state exchanges. While this may increase availability of insurance, it is not known what will happen to the price of insurance in the exchanges. Many are concerned that insurance will be costly due to requirements around essential benefits.

In addition to health care providers and insurance professionals, many other professionals are important to the industry. In the health insurance industry, brokers typically assist individuals and small groups in identifying and comparing insurance products, while consultants often large employers on plan design and cost management. Brokers are often paid a commission by the insurance company selected, while consultants are typically paid by the employer customer.

The health care industry is an important source of jobs: not discussed in this publication but critical to the industry and U.S. economy are millions of employees in the health information technology, medical and surgical device, pharmaceutical, and health care administration industries.
1.3 Types of Health Plans

Over the years, health plans have grown to have many different forms and products. A health insurance product packaged with a network of health care providers who agree to provide care is called a health plan. The alternative to health plans is indemnity care, described below. Fee for service (FFS) is a way of paying for services – it can be used by insurance companies either with a health plan arrangement or with indemnity care. Outside of Medicare, which remains an enormous indemnity program, most health care in the use is provided through health plans of the types below:

Preferred Provider Organization (PPO)- PPOs are the most common type of health care plan. A PPO is an arrangement in which an insurance company contracts with or creates a network of providers. A PPO plan is an insurance arrangement that accepts insurance risk; a PPO network is a non-risk organization that offers access to providers but does not insure members. (The insurance is provided either by the employer or another company renting the PPO network.) In a PPO, the providers agree to discount their rates to PPO members. Members can visit providers in the network to get the lowest costs, or they can pay more and see any provider they wish. The PPO may rent access to its rates and the provider network to other insurance companies. PPO networks may be part of many types of insurance arrangements, including consumer directed health plans (CDHPs). More details about PPO arrangements are provided in Chapter 2.

Health Maintenance Organizations (HMOs) - HMOs are a combined network and insurance arrangement. HMOs are at risk for the costs of health care, and usually require members to seek care from a defined network of providers. By contracting with a select group of providers, HMOs can more carefully manage the cost and the quality of care. Many HMOs now offer a Point of Service (POS) option, which allows patients to obtain care outside of the HMO network, but at a higher cost. In the past many HMOs did not pay for any care the patient received outside the network. With POS and other arrangements, many HMOs now allow out of network care.

Indemnity Plans – Health insurance plans that pay for covered services on a fee-for-service basis are known as indemnity plans. While this was the most common approach 30 years ago, there are virtually no cost or quality controls in an indemnity plan. Indemnity plans do not require enrollees or patients to use a specific network of providers.

Within these types of arrangements, insurers can create different types of insurance products. Various products include high deductible health plans (HDHP) and consumer directed health plans (CDHP). High deductible plans are often paired with a tax-advantaged savings arrangement called a Health Savings Account. HDHPs and CDHPs often include a PPO network arrangement, so the consumer will have a higher benefit level when using an in-network provider regardless of whether the consumer’s dollars or insurance company dollars are used.

Some specialty plans also exist, and are paired with one of the insurance arrangements described above. Either the health plan can contract with a specialty network, or an employer can purchase access to both a medical plan and a specialty plan to make them both available to beneficiaries. Specialty plans include:

- Prescription drug plans
- Behavioral health plans
- Specialty health plans (wellness, chiropractic and others)
- Dental and vision plans
It is important to note that **discount cards are not insurance**. The discount card provider purchases access to a network and through an agreement, makes discounted fees available to the consumer. In a discount card arrangement, the patient is responsible for all of the fees (not an insurance company).
1.4 Benefits

Covered benefits are those services for which the insurance company or health plan has agreed to pay. Patients need to know what benefits are covered; this information is usually provided to patients in a Benefit Plan Brochure and a Benefit Plan Summary. These items are kept up to date by the plan or employer so that the patient knows what to expect when using or planning to use services.

Typically inpatient and outpatient medical, surgical, diagnostic and ancillary benefits are covered by most plans. Many plans also pay for alternative care providers including chiropractic or wellness providers, and for pharmaceuticals. Since Mental Health Parity legislation was passed, health plans that offer mental health benefits must cover them at the same level at which non-mental health benefits are covered.

Most benefits are only covered if they are considered “medically necessary.” Health plans define medical necessity based on examination of the science and professional judgment of physicians. In the health care field this is called “evidence based medicine.” The “evidence” is made up of published scientific data and professional recommendations on what is effective health care. Many physician organizations periodically review all of the scientific studies in their area and generate recommendations called clinical practice guidelines. Health plans base their medical policy on medical necessity on these research studies and clinical practice guidelines.

By requiring that services be medically necessary, insurance plans avoid paying for services that are discretionary or cosmetic. Generally patients must pay for discretionary services themselves. Health care premiums rise as health care costs rise, hence the interest of insurers in paying only for medically necessary services.

Health plans may also define the frequency or volume of services they will cover. For example a health plan benefit summary may indicate that the plan will cover only a certain number of physical therapy visits per year, or may limit routine preventive screenings such as mammography to once per year, as recommended by professionals. Benefit plans may also describe exclusions. Particularly for self-insured plans, the employer may elect not to pay for certain services (such as experimental treatment). The PPACA now prohibits exclusions for “pre-existing conditions,” a practice by which plans would exclude treatment coverage for beneficiaries if they had the condition prior to joining the health plan.

In recent years some health plans have also placed restrictions on the location of covered services. Some plans now require that certain high risk procedures such as weight loss surgery or open heart surgery be carried out in high-volume hospitals, since the outcomes are likely to be better. A tiered health plan may offer better benefit coverage if the patient uses selected providers; providers not in the highest tier will be covered, but with higher out of pocket expenses to the patient.

New in PPACA: Preventive services are now a mandatory benefit for commercial health plans, and they must be covered with a zero co-payment. The services identified as covered benefits will be determined based on recommendations of a federal work group called the U.S. Preventive Services Task Force (USPSTF). The USPSTF is made up of private sector representatives who review the research evidence and identify those that have proven preventive benefits. The PPACA specifies that preventive services recommended by the USPSTF as levels A or B, e.g. there is a high level of certainty that they are effective, must be covered benefits under regulated health plans.
Footing the bill for health care in the U.S. are employers, the federal government, state government, and individuals. Many, many other organizations have a role in arranging health care services and administering health care plans.

**Payers**

The organizations that pay for health care services are referred to by multiple terms. Terms frequently referenced are **payers, purchasers, or plan sponsors**. Depending on whether the service is fully insured or self-insured, the payer may directly fund or insure the service, and has more or less control over the dollars.

**Employers:** The U.S. health care system is an “employer-based” health care system, in which employers may pay all or part of health care premiums on behalf of workers and their dependents. The federal government is one of the major payers, directly paying for individuals receiving Medicare, and contributing to state-run Medicaid programs. The government also pays for federal and military employees, although the military maintains its own health care arrangements.

Employers may “self-insure,” e.g. make payments into a reserve to pay the cost of health care. Typically large employers self-insure to create their own health plan, often referred to as an **ERISA plan** (ERISA is the legislation that exempts large, multi-state employers from state insurance regulation). Even in a self-insured arrangement the employer chooses the type of plan - PPO, HMO, or POS. Or, the employer can offer a high deductible plan paired with a health savings account. These are often administered by a health insurance company.

Alternatively employers may purchase health insurance, choosing among the product types discussed above. Smaller employers generally do not have the option to self-insure – that is because they do not have enough “lives” to spread out the financial risk. Even if they pool payments for all employees, one very costly health care problem can wipe out the reserve. Large employers have pooled enough dollars that they can absorb a greater financial loss. Thus small employers are more likely to be “fully insured,” e.g. they purchase a pre-packaged insurance plan from an insurance organization. **Insurance brokers** have a role in vetting insurance products meeting the needs of these employers and helping to arrange coverage.

In any arrangement, the employer plays a large role in choosing the amount the member must pay in the form of a deductible or co-pay, and also chooses covered benefits. Self-insured plans have more flexibility in the benefits to offer than do plans fully insured by another company. Insurance companies are subject to **state regulations and benefit mandates**, while self-insured companies are not. Self-insured employers choose what type of health plan to offer for their beneficiaries, and determine the level of benefits to offer.

Together the organizations that pay the health care bills, either the employer, an insurance health plan or the federal government, are called payers. Increasingly, payers have taken an active role in controlling costs and improving quality in the health care system.

**Government Entitlement Programs** – The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for administering the Medicaid and Medicare programs.
• **Medicaid** – Medicaid is a joint federal state program for low income people in certain needy categories. Medicaid is available to citizens and sometimes legal immigrants who are pregnant, disabled, blind, or aged. The rules for counting income and resources vary from state to state and from group to group, as do the benefits. There are special rules for those who live in nursing homes and for disabled children living at home. Some states have opted to administer Medicaid benefits through contracted health plans (managed care), while others use FFS or a type of modified managed care known as “primary care case management.”

• **Children’s Health Insurance Program**: CHIP is also federal state program designed for low income children. Some states manage the CHIP program through the same administrative processes as the Medicaid program, but others administer it as a distinct program.

• **Medicare** – Medicare is the national health insurance program for people age 65 or older, some people under age 65 with disabilities, and people with end-stage renal disease, which is permanent kidney failure requiring dialysis or a kidney transplant. The majority of Medicare beneficiaries are in FFS Medicare, although Medicare Advantage Plans provide services in some states. Reform of Medicare may involve greater use of health plans or other arrangements in which quality and cost of health care services can be more carefully evaluated.

**Government Employees and Armed Services** – The federal government is the largest purchaser of health care in the United States.

• Federal employees are covered through the Federal Employees Health Benefits Plan (FEHBP). FEHBP offers many health plans, each of which agree to provide standard services and which may add other services. Employee options vary by region but the minimum benefits are standardized. Employees can choose the plan they want based on benefits, provider network and payroll deduction amounts.

• **TRICARE** – TRICARE is the Department of Defense’s worldwide health care program for active-duty and retired uniformed services members and their families. TRICARE brings together the health care resources of the uniformed services and supplements them with networks of civilian health care providers.

**State and local government** entities are also purchasers of health insurance for their employees. They are often one of the larger health care payers in their localities, and thus have clout in influencing the local health care market.
Health Insurance Arrangements

Some examples of the types of arrangements that can be made for insurance include:

**Trade Associations** – Small businesses with fewer than 50 employees frequently join trade associations and pool their purchasing power to improve their ability to negotiate better prices for a variety of services, including health insurance. These arrangements are called Multiple Employer Welfare Arrangements, or MEWAs. **Association health plans (AHPs)** are a variant of this arrangement that would allow associations of small businesses to join as a group to self-insure. Multi-state AHPs are not currently allowed under state insurance regulation.

**State Exchanges**: Under health care reform enacted in 2010, individuals and small groups will be able to purchase insurance from newly created state exchanges. Exchanges will operate similar to the FEHB program, offering health plan options that agree to provide a standard set of “essential health benefits.” Plans participating in the exchange may also offer other services but may not provide less than the essential benefits. Many individuals and those that are self-employed are responsible for purchasing their own health insurance, often because they are not eligible for participation through employers or the employer does not offer insurance.

**Third Party Administrators**: Self-insured employers commonly use a third party administrator (TPA), or administrative services organization (ASO) to administer the claims and provide other health management services. The employer still assumes the risk for the medical claims costs but outsources the actual claims processing and payment. The TPA is a non-risk-bearing organization that is paid a fee for its services. The ASO or TPA provides administrative support that can include any combination of administrative services described in the next section.

**Administrative services**: Health plans typically provide a variety of services needed to keep the plan functioning smoothly and to prevent fraud. Services are designed to ensure that the contracted network of providers is paid promptly and correctly, that payments cover only eligible beneficiaries, and that beneficiaries get the most value from their benefits.

| New in PPACA: | Health care reform legislation defined administrative services as any service not related to direct reimbursement of claims or improvement of health care quality. **Medical loss ratio** (MLR) requirements specified that plans must pay a specific percentage of their total dollars to pay for claims. MLR requirements are designed to force plans to find efficiencies in administrative services and reduce profits. Some health plans have also expressed concern that it may force them to reduce availability of services that reduce costs in the long run, such as fraud and abuse prevention and medical management services. Health plans want all quality-related services, including credentialing and fraud and abuse activities to be considered quality activities in MLR calculations. Also of concern to the industry is the treatment of broker fees in MLR calculations. If broker fees are included as administrative costs, plans may cut back on these services resulting in reduced access to services and loss of brokers’ jobs. |

Administrative services offered by insurance companies to fully insured or self-insured clients typically include:

- **Employee Enrollment** – Creating and printing enrollment materials and assisting employees in applying for their coverage
- **Eligibility Management** – Keeping membership records accurate and interfacing with payroll staff to reconcile the records of enrolled employees with the funds gathered through payroll deductions
- **Claims Processing and Payment** – The complex process of adjudicating health insurance claims according to the employer’s benefits plan and issuing checks to providers or employees
- **Education** – Educating employees regarding their benefits and how to use their health care coverage
- **Customer Service** – Responding to questions and assisting in solving problems concerning eligibility and claims processing by telephone, e-mail and other forms of correspondence. Inquiries might come from employers, union representatives, employees or providers of services (e.g., physician’s office, hospital, laboratory)
- **Medical Management** – May include utilization management (preauthorization of non-emergency hospital care, such as elective surgery), case management (management of serious inpatient cases, such as cancer) or disease management (inpatient and outpatient programs to help patients manage chronic diseases, such as diabetes)
- **Quality management** - maintaining accreditation status as required by many states and employers, and carrying out initiatives that can improve care outcomes or reduce costs
- **Reporting** – Developing and producing reports to assist the employer in understanding and analyzing its health care costs; reporting also includes producing health care quality reports using standardized approaches such as HEDIS (described in Chapter 3)
- **Network management** – identifying physicians, hospitals and other providers to deliver services in network, and negotiating discounts and quality standards
- **Credentialing** – verifying the license and training of professions to ensure they are in good standing, and checking to ensure that the providers have not committed fraud or malpractice
- **Fraud and abuse prevention/detection** - applying algorithms to claims data to detect patterns that could signify fraud, and investigating any potential areas of concern
PPO Primer for the Public Policy Community

Chapter 1 -- Overview of Insurance Issues

1.6 Health Care Providers

Health care provider is a general term that refers to physicians and other clinicians, and hospitals and other facilities. United States has one of the most technologically advanced health care systems in the world and has a diverse array of facilities and practitioners delivering services. Health plans contract with providers and interface with these practitioners through claims, the invoices submitted by the practitioner.

Each insurance claim includes a unique identifier for the provider (a National Provider Identifier number) along with information about the services provided. The insurance company processes the claim to ensure the provider and service are covered, and then to apply the appropriate pricing plan. Through claims, insurance companies capture important information about patients, providers, and pricing.

Practitioners and institutions that typically bill for services include the following:

- **Hospitals** – Institutions that are built, staffed and equipped for the diagnosis of disease; for the treatment, both medical and surgical, of the sick and the injured; and for their housing during this process. Hospitals also often serve as centers for investigation, research and development, and teaching. Centers of Excellence are hospitals that specialize in a specific type of care or procedure, including transplants, heart surgery or other types of care.
- **Physicians** – People who have been trained as medical doctors and who have been licensed by a state to practice medicine include the following:
  - M.D. – A physician who received a degree as a doctor of medicine
  - D.O. – A physician who received a degree as a doctor of osteopathy
  - Specialist Physician – An M.D. or D.O. who has received special training in a specific medical discipline (e.g., anesthesiology, cardiology, general surgery, ophthalmology)
- **Behavioral Health** – physicians and other licensed professionals including nurses and social workers provide specialized services for serious mental illnesses and substance abuse treatment. Employee Assistance Programs are a specific type of service often offered by behavior health organizations. EAPs designed for employees to provide easy access to any service that will help them remain productive and on the job. EAPs typically include behavioral health screening and referral for problems such as alcohol misuse, but may also include financial counseling, assistance with child care arrangements, and other services.
- **Advanced practice clinicians**: Most states and the federal government recognize a category of practitioners that includes advance practice nurses such as nurse midwives and nurse practitioners and physician assistants. These clinicians receive advanced training to see patients independently and to deliver a specific scope of services. Legal authority to prescribe and treat varies by state, but in some states these practitioners work independently and may bill for services.
- **Ancillary Providers** – Include a broad range of providers and services that may be freestanding or affiliated with a hospital or physician office, including, but not limited to the following:
  - Laboratory – Collects, analyzes and provides reports regarding the cellular structure and chemical contents of blood, tissue, urine and other types of samples
  - Radiology Center – Produces images of the human body using X-rays, CAT scanning and MRI
  - Freestanding Surgical Center – A health care facility that provides short-term medical care for prescheduled outpatient surgery and invasive examination. The center may be independently owned or part of a hospital.
- **Alternative Care Providers** – Americans have shown increasing interest in using alternative care practitioners, including chiropractic, acupuncture, homeopathic and other providers. Insurers and PPOs increasingly offer benefits for such care and create specialized networks of authorized
alternative care providers. Examples of specialized networks include optometry, podiatry, physical therapy, sleep therapy, chiropractic, vision and dental networks.

A community may be large enough to have all of these services locally. People in smaller towns and rural communities have to rely on large hospitals, frequently at major universities, to receive care for complex conditions or severe injuries. Typically, hospitals specializing in the care of children and burn victims, and in organ transplants and other infrequent procedures, provide services for a very large area, sometimes for an entire state or region.

**Primary care providers (PCPs)** are physicians, advanced practice nurses and sometimes physician assistants who are trained to diagnose, treat, and manage illnesses. They are usually the first provider seen by the patient and can deliver a broad range of services. PCPs refer their patients to specialists when the patient needs diagnosis or care for a complex condition. **Specialists** are trained in a specific type of medicine (such as cardiologists for hearts or dermatologists for the skin) and often use medical procedures to treat the patient.

**New:** More attention has been paid recently to a potential lack of primary care providers. Expanded insurance coverage under PPACA is expected to exacerbate a shortage of PCPs. It is widely accepted that people who have high quality care from PCPs are less likely to need hospitalization or to return to the hospital after an admission. Rural areas have experienced shortages for many years, as have less desirable locations for practice (such as inner cities). Health care reform is expected to increase insurance coverage for more people, leading to greater use of primary care services, and an exacerbation of shortages. Options for addressing the shortage include training more primary care physicians, expanding the scope of practice for advanced practice clinicians, changing the style of practice, for example, by using group visits for patients with the same condition, or expanding use of technology such as web consultations.

**Provider Arrangements**

The traditional “**solo practice**” model that we are familiar with from TV is rapidly becoming a thing of the past. Now, physicians need access to capital to purchase equipment and electronic systems to manage billing and information. The majority of physicians practice in groups, either made up of a single specialty such as pediatrics, or a “**multi-specialty group.**”

Group practices allow for increased efficiency in developing and managing contracts with insurance companies, billing, managing patient information, and managing patient care after hours. Larger groups typically have more financial capital to purchase hardware and software that increases their efficiency and to expand to multiple office locations.

**New in PPACA:** recognizing that lack of provider coordination results in inefficient care and sometimes worse outcomes for patients, PPACA introduces two new types of arrangements. Accountable Care Organizations (ACOs) are intended to improve coordination of hospital and high intensity services. Patient Centered Medical Homes (PCMHs) are primary care offices that can provide improved services for people with chronic illnesses and that use electronic systems to increase information sharing and efficiency.

Hospitals typically have two mechanisms for getting new patients – emergency rooms and physician referrals. Hospitals rely on agreements with physicians to refer patients and “fill beds.” For example, hospitals offer operating rooms and post-surgical care as an incentive for surgeons operate in the hospital. Both parties benefit as they are each eligible to bill for the services (the physicians for the actual intervention (typically called the professional services component of a bill), and the hospital for the facilities and patient care). Hospitals will often review the physician’s credentials and malpractice history before granting “**privileges,**” but don’t usually have other quality requirements for physicians.
For physician specialties where the physician does not generally have his/her own office practice, such as emergency care and anesthesiology, the hospital might enter an exclusive agreement with a single group of specialty physicians to provide all of the care for patients in the hospital. Specialty group contracting arrangements are more convenient for the hospital than contracting with multiple physicians and having to manage “coverage” of the hospital for services 24 hours a day (since the medical group will carry out this function).

PPOs and HMOs typically contract with multiple hospitals to provide care for the covered beneficiaries. They often ask the hospital to develop quality improvement programs or meet efficiency standards. This is more complicated than it may seem, since hospitals have little control over the referring physicians who use the hospital. And where a specialty group provides all of certain type of service such as anesthesia or emergency care, these contracts can cause problems for a PPO or HMO. If the hospital agrees to be a preferred provider but the specialty group providing services within the hospital does not, patients can end up confused and holding a bill they did not expect to pay.

**New:** Health care experts have recently begun using the term “Integrated care” to refer to an optimal system in which multiple providers can coordinate care for the patient at all levels – outpatient and inpatient, using electronic information systems. Information integration would mean that laboratory, specialty, and physician care could all be accessible when needed, and that information could be used to identify the patient’s clinical needs and evaluate the quality of care. Integration contrasts to the fragmented care currently the norm in the U.S. While all the excellent physicians are doing the best they can for the patient, many times the right hand does not know what the left is doing. In our current fragmented system the patient’s records are often not available, resulting in the need for duplicate testing or mishaps due to lack of information. Because no single provider is responsible for the patient, many opportunities are missed to prevent an illness or relapse, resulting in sicker patients and more costly care.
1.7 Setting Health Insurance Premiums

Insurance companies are regulated by state law and must be licensed by each state in which they wish to sell policies. The rates they charge are also regulated; each year each insurance company must file its rates and benefits plans with each state’s regulatory agency. A policy “rating” is the process of identifying factors that influence the probable costs and that should be factored into the premium, or rate charged to the payer.

Health insurance reform legislation changed the way premiums could be established in the commercial market. Insurance companies may consider age and family size to develop premiums. However, the difference in premiums between the youngest members and the oldest members is now fixed. They may also charge higher premiums to tobacco users. Insurance companies can also factor in the location of the service, since some areas of the U.S. have significantly higher prices for health care than others.

Insurance companies may no longer factor in gender, the size of the covered group, or specific health conditions of members of the group. Health insurance plans can also no longer exclude coverage for specific conditions in specific people. (For example, in the past, if a person enrolling in the health plan was known to have high blood pressure, the insurance company could offer that person a policy but exclude coverage of treatment for high blood pressure. That is no longer allowed. If the plan covers high blood pressure for some people, it must cover it for all.)

The insurance industry collects data to develop rate-setting methods that are actuarially sound, e.g. the expected income will be sufficient to cover expected expenses, plus reserves and profit. Each time an employer applies for health insurance, the insurance company gathers data about the employees and develops rates that it believes are competitive while covering the financial risk that the insurance company is willing to assume.

New with PPACA: Under PPACA, insurance companies must use “adjusted community rating,” e.g. set premiums according to the factors identified above but not according to the costs experienced in a certain group. They must also “guarantee issue” a policy, e.g. offer it to any group that asks, and may not rate the policy based on or exclude preexisting conditions. Some companies have expressed concerns that new restrictions on rate setting may result in inflation of premiums as insurers set premiums high enough to cover any eventuality, or losses to the insurer, or insurance companies dropping out of risky market areas.

Following a rate-setting process approved by a particular state, the insurance company develops rates for contracts covering:

- **Employee Only** (sometimes called single rate) – Represents the rate for covering the employee only, including both men and women
- **Employee and Spouse or Child** (sometimes called two-person rate)
- **Family** – Includes the employee, the employee’s spouse and all qualifying children

Sometimes the insurance company expands the three-tier rates above to four- or five-tier rates, which typically fall into the following categories:

<table>
<thead>
<tr>
<th>Four-Tier Rate</th>
<th>Five-Tier Rate</th>
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<tr>
<td>Employee</td>
<td>Employee</td>
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<tr>
<td>Employee and Spouse</td>
<td>Employee and Spouse</td>
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</table>
Sometimes employers pay the entire health insurance premium. Typically, employers pay a portion of the premium and the employee pays the balance. This employee contribution is collected by taking a payroll deduction from each paycheck.
1.8 Health Information and Information Sharing

The health care industry lags behind other industries in adoption of information technology (IT) to transmit information. For example, consumers have long been able to manage their finances, comparison shop for clothes, and even shop for houses on the internet. In contrast, information management in health care is in its infancy. While most hospitals, insurance companies and physicians have websites, very few of them are able to transact business this way.

In an ideal world, patients could set up appointments, communicate with their doctors, compare prices and services at available hospitals, and even check their latest lab results. In an ideal world physician’s work would be simplified as well. They could submit bills to insurance companies electronically, check status of payments, check on their patients test results in the hospital, and see which patients in their care need preventive and follow up services.

The health care industry is moving slowly in the direction of electronic records and transactions (called health information technology, or HIT), but the pace of adoption has been slow. There are many factors underlying the slow uptake of HIT. The lag is in part due to lack of capital in physician and hospital practices. It is also due to the potential for reduced productivity in the physician offices during the phase in, a loss most physicians could not afford to take. Physicians cannot bill either for HIT purchases or for the lost time while they learn new systems. This is not the case in other areas of technology such as cancer treatment and new surgical technology, which are billable events. In use of technologies that billable services, hospitals and physicians are among the early adopters.

Another important barrier to uptake is lack of “interoperability” of IT systems. That is, an electronic health record in a physician’s office would not necessarily communicate with the hospital’s records or the records of a nearby specialists. Physicians are waiting for IT systems to have the ease and interoperability they need to make them meaningful for care management.

New: In 2009 as part of the Recovery Act, the federal government began making incentive payments to physicians to promote adoption of electronic medical records (EMRs), subject to providers’ meaningful use of the technology to deliver services to Medicare and Medicaid recipients. Even with incentives adoption has been slow due to other barriers identified above.

HIPAA

The Health Insurance Portability and Accountability Act was established to protect the privacy of patient information. HIPAA requires that patients consent to the use of their information if patient identified information is relayed. HIPAA allows for “de-identified” data to be used for quality improvement and research.

When an insurance company wishes to transmit identifiable information, for example, to refer a patient for disease management services, the patient must consent and the insurance company must have a business associate agreement with any organization receiving patient information. A business associate agreement (BAA) requires both organizations to adopt policies and procedures to protect information from unauthorized sharing and to comply with HIPAA.

While HIPAA is an important consumer protection, it has also impacted the pace of technology adoption and communications between providers. Many providers believe that they cannot communicate electronically with patients because there may be a breach of protected information. New systems are...
under development to allow secured communications between providers and patients, and to allow for permissible sharing of patient health information and records among providers.

**ICD-10**

The U.S. uses a system called the International Classification of Diseases (ICD) to classify diseases and treatments for the purpose of billing. ICD information is also used for research on how care is delivered and the outcomes. The country is in the process of transitioning from one generation of health care coding (ICD-9) to the next generation, ICD-10. This is a major information management undertaking. The ICD-9 code set contains approximately 17,000 codes, while the ICD-10 contains exponentially more, at approximately 141,000 codes.

A "claim" is the provider's bill for health care services. Each claim includes coded information about the patient diagnosis and the services provided. The new codes in ICD10 will greatly expand the information available on the claim. It will help insurers to track care and quality. But, the change is expected to be costly and time consuming. The transition requires physician offices to upgrade billing software and retrain their staff on how to properly code information from visits.

Similarly insurers are required to upgrade their software to accept the new billing codes and to pay them properly. Insurers must create complex crosswalks to show how ICD9 codes will convert into ICD10 codes. The conversion is expected to generate significant costs in the system until well after it is fully implemented in 2014.
1.9 Patients and Beneficiaries

Many terms are used in the insurance industry to refer to the people covered under insurance. The meaning of the terms are very similar, and they are often used interchangeably. A member, subscriber or beneficiary is someone who is eligible for benefits whether or not the person uses them. (In this primer the patient is someone who sees a health care professional. A consumer is someone who makes decisions about health benefit plans and health care services. That person may become a patient but isn’t always a patient.)

In the insurance industry the employee is frequently referred to as “the insured” and other eligible members of the family are known as dependents. In a health insurance plan such as an HMO, beneficiaries are often called members. In a network arrangement where beneficiaries might be enrolled not by name, but as “employee and dependents” beneficiaries are often called “enrollees.” Together, the group of employees and dependents covered by an insurance plan are called the “covered lives.”

Until relatively recently, the purchasing power of enrollees was virtually overlooked in the health insurance industry. Employers or the federal government paid for the health care services and providers delivered the services. Patients were thought of as passive participants. Now there is general recognition that as in any other transaction, patients must be active partners both in the health care services and in the financial transactions around the services. There is a trend towards increased consumer cost sharing in HSA products, and insurers are also examining the possibility of scaling consumer payments based on high value and low value of the service.

Health care has traditionally not been “transparent” to consumers – e.g. most consumers have no idea of the price of services, and have little understanding about quality of care. There has been pressure from consumers and insurance plans to make price information more widely available to consumers to help them choose the most cost effective providers. If consumers are expected to exert more power in choosing health benefits and health care providers, they must have more information about the cost of products and the quality to support their choices.

Efforts to increase price transparency have been controversial. Providers argue that price alone is not a sufficient criterion with which to select a provider. Provider level quality metrics, while used extensively in the industry to assess insurer quality, are in their infancy and often are challenged in their accuracy. Many providers are reluctant to disclose the prices they charge, which they feel could put them at a competitive disadvantage.

Most experts believe that eventually price and quality transparency must become widespread in the healthcare field in order to promote competition. Transparency benefits patients too, since they often have a co-payment and deductible to satisfy before insurance coverage kicks in. It is likely that the internet will increase the pace of transparency and consumer engagement in health care, just as it did in auto insurance, automobile purchasing and other critical areas of consumer spending.
Chapter 1 -- Overview of Insurance Issues

1.10 Payment and Cost Control Approaches for Health Services

Everyone knows that the cost of health care is rapidly increasing. Some of the factors underlying cost increases are an aging population, more services being provided, and more ways to provide treatment. The U.S. is justifiably proud of having the most advanced health care system in the world. Our system constantly innovates with new technologies and treatments. But, new technologies and treatments can be costly, and as our ability to treat conditions goes up, so does the use of services and the costs.

Two potentially controllable factors have a major influence on the high cost of health care: price of services, and volume of services. Many health economists have seen opportunities to control costs by taking out some of the waste in the system such as duplicate tests and, preventable hospitalizations. The health insurance industry has developed methods to manage both price and volume. But, health care decisions are ultimately made by doctors and patients. The historical strategy taken by the health insurance industry is to provide information that can help guide decisions and provide incentives for best practices, but to leave treatment decisions to the health care providers.

Types of Payments

Even in managed care arrangements, insurers typically reimburse providers based on each service they provide, a system known as fee for service (FFS). FFS may be a discounted fee, but it is still based on each unique service or a bundle of services provided. FFS is considered an inflationary method of payment, since it inherently creates incentives for providers to offer more services to maximize reimbursement.

Capitation, is the primary alternative to fee for service. Capitation pays providers prospectively, e.g. it sets an expectation based on actuarial analysis and pays the providers for just that much care. Providers are paid a fee for all the services expected to be delivered for a group of patients, and therefore have an incentive to stay within the global budget.

Capitation was used more extensively in the 1990s but fell out of favor because it was believed to create incentives for providers to reduce necessary care. Fee for service, on the other hand is generally recognized to create incentives for providers – hospitals and physicians – to generate more billable services. Much of the debate around health care financing now is how to “align incentives” so that doctors can be fairly paid and have incentives to deliver the right care and the right volume of care.

Price Management

Billed Charges: Physicians and other practitioners are independent practitioners and have the power to bill any fee they wish. However, as terms of a network agreement, insurance companies generally negotiate either a discount from billed charges, a fee schedule, or a UCR arrangement discussed below. Billed charges are generally the highest price that can be paid for a service. Unfortunately, it is often patients paying their own bills who are required to pay the billed charges, since patients covered by insurance or Medicare are covered by the discounts arranged by the payer.

Volume discounts: In a network arrangement such as an HMO or PPO, the network negotiates discounted rates with providers, including physicians, hospitals, and specialty care providers. Discounts may be applied to billed charges, to the UCR, or to a fee schedule. Providers are willing to participate in discounted arrangements for a variety of reasons, including the market value of increased volume and expedited payments. PPO and HMO networks negotiate a specified discount with each provider, generally discounting against one of the fee structures discussed below.
UCR: The insurance industry has developed methods for paying medical claims based on the prevailing local prices. The insurance company usually develops its own base payment level, called the usual, customary and reasonable charge (UCR, also called similar names, including “reasonable and customary”). UCR is the prevailing cost of a medical service in a geographic area for all of the providers or all providers in the network, for a given service.

Case Example: Usual, Customary and Reasonable

A laboratory charges $25 for a particular blood test. One insurance company has a UCR charge of $20 for that service, while another insurance company has a UCR charge of $18. Assuming that the insured person has met any required deductible and the benefits plan pays 100 percent of UCR charges, it would pay for the service based on UCR billed charges: $20 or $18, depending on the company. If the laboratory is in the patient’s PPO or HMO network, there is no “balance bill” sent to the patient. If the laboratory does not have a contract with the insurance company, the laboratory may bill the insured person the difference between its $25 charge and the insurance company’s UCR charge ($5 or $7, depending on the insurance company.)

This example illustrates that different insurance companies contract with providers for different rates. It is more cost effective for the patient to visit a provider “in the network” to avoid balance billing.

Fee Schedule: A fee schedule is a complete listing of fees used to pay doctors or other providers. A fee schedule is an alternative to UCR or discounted billed charges. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. The Medicare fee schedule is commonly used by insurance companies to set pricing and discounts with network providers. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

Bundled Services and DRGs: Rather than pay for each individual service (such as a visit, an injection, a lab test and an educational intervention), many insurance companies pay for a bundle of services that includes all of the essential elements of care. DRGs, or Diagnosis Related Groups are bundles of hospital services related to care of a condition. For example, Medicare can pay one price for the DRG related to care of heart failure. DRG pricing brings an added measure of predictability to hospital costs. During the term of the DRG agreement, the PPO’s customer is protected from inflation in prices for hospital services, pharmaceuticals and supplies provided by the hospital, and from variability in the total number of days of hospitalization. DRGs make hospitals active partners with the PPO in controlling utilization, since any savings realized in the number of days of hospitalization will accrue to the hospital, rather than to the PPO’s customer.

Episodes of Care: DRG payments are based on one hospital stay, regardless of how frequently the patient returns to the hospital. Some experts think that this caused hospitals to discharge and re-admit patients without ensuring that all health needs were met. Within the past few years, insurance companies have started to develop payment models for “episodes of care.” An episode is considered the period of time before and after an acute event such as heart failure. Providers and hospitals are responsible for completely resolving that episode before a plan will reimburse for the same service again.

Relative Value Scales: Two relative value scales are used for most fee schedule development. Relative Values for Physicians, published by St. Anthony Publishing and Ingenix Publishing, is used by a small number of PPOs. The Resource Based Relative Value System (RBRVS), used by the Medicare program, has increasingly been adopted as the basis for fee schedules developed by PPOs. St. Anthony Publishing and Ingenix Publishing produce a version of RBRVS that includes all the services valued by Medicare for the over-65 population as well as values for many of the codes not valued by Medicare.
Per Diem Payments: Another method of reimbursement used commonly for hospital inpatient services is a per diem payment. Per diem rates are established for several categories of care, such as medical, surgical, obstetric, intensive care, and neonatal intensive care. For each day a patient is hospitalized for one of these types of services, the hospital receives the per diem payment, instead of the hospital’s daily room charge and charges for operating room time, supplies, pharmaceutical items and other items. Under this pricing model, the hospital assumes some risk that the physician will keep the patient in the hospital long enough to allow the hospital to recover the higher costs usually incurred in the first day or two of a hospital stay. Some PPOs negotiate higher per diem payments for the first day of a hospital stay, with lower per diem rates for subsequent days.

Per diem pricing brings some measure of predictability to hospital costs. During the term of the per diem, the PPO’s customer is protected from inflation in prices for hospital services, pharmaceuticals and supplies provided by the hospital.

Case Rates and Bundled Case Rates: Case rate pricing may be developed by PPOs to cover certain high-volume services at specific hospitals. Case rates may apply to services such as obstetrics, psychiatry, cardiovascular surgery or other services for which the PPO and hospital can agree on a fixed rate of reimbursement for each admission. Bundled case rate pricing, in which a package price is established for all institutional and professional services, is occasionally used to cover very high-cost procedures, such as transplants. Once the bundled case rate is established, that fixed amount is used to pay all who provide care to the patient during the pre-admission, inpatient and an agreed-upon post-discharge period. Teaching hospitals, with their faculty practice plans, are in the best position to contract on a bundled case rate basis.

Insurance companies can adopt various methods for paying claims, which are explained briefly below.

- **Hospital Services** - are paid using many methods:
  - Billed charges up to the benefits plan limits
  - Percentage of billed charges, also called “payment based on discount from charges”
  - Per day rate for each day of hospitalization, called a “per diem”
  - Case rates based on specific conditions or treatments; for example, a fixed amount for a class of surgery that could include similar surgeries, such as an appendectomy or gall bladder removal
  - DRG – a fixed amount for a case, determined by the Diagnostis Related Group (DRG) into which the case falls

Professional services by physicians and other providers working inside the hospital are billed separately from the hospital’s services. Most often, hospital physicians are independent contractors and are not employees of the hospital. The hospital affords these professionals “privileges” but does not have control of their volume or practice patterns.

PPOs and HMOs contract with both hospital facilities and providers in their networks. Because physicians are independent from hospitals, sometimes an “out of network” physician may see a patient at an “in network” hospital. This is particularly true for emergency services. Out of network billing by providers at in-network hospitals has been the subject of many patient complaints.

- **Professional Services** – Services of physicians and other health care professionals, such as podiatrists, physical therapists, chiropractors, and others are billed using the CPT-4 coding system. The American Medical Association has developed the CPT-4 coding system, which has more than 11,000 codes describing and differentiating between individual services that can be provided by physicians and other health care professionals.
Services are billed by the provider using the appropriate CPT-4 code and reflecting the provider’s billed charge. As with hospital services, several payment methods are used by insurance companies for professional services:

- Billed charges, up to the benefits plan limits
- Percentage of billed charges, also called “payment based on discount from charges”
- Fee schedules based on UCR charge formulas or other unit value systems adopted by the insurance company
- Fee schedules based on the Medicare Resource Based Relative Value System (RBRVS). This is the most common payment method.

**Hospital-Based Ancillary Providers** - are providers of services such as radiology (X-ray) and laboratory work that are physically located in the hospital and use the hospital's equipment but are staffed by independent physicians. For these services, two bills are sent to the insurance company: one by the hospital for the “facility services” (technical component) and a second by the physician for the “professional services” (professional component).

### Volume Management

Where Medicare and commercial insurance plans have reduced the price for many services, experience has shown that the volume of services continues to increase. In particular the U.S. health care system has seen an explosion of services such as high cost radiology exams, home health services and certain other services. The goal of reducing volume of care and ensuring only appropriate care be provided has to be balanced with the concern that care not be rationed or inappropriately restricted. Companies use profiling and utilization management to help control volume, but overall these programs have not been enormously successful.

**Utilization management** (UM) programs are designed to ensure that the volume of care and the particular service selected is appropriate. Providers and patients are notified which services must be “authorized” in advance of care. Often elective inpatient stays, high cost radiology, and continued hospital stays are subject to UM review. For example many plans use UM to control use of radiology services, which are both costly and expose the patient to harmful radiation exposure. UM for radiology may try to steer the patient to a test that will offer the same information with less risk of radiation exposure.

**Out of Pocket Costs** to patients have an influence on how likely they are to seek care or to shop for services. Most typical insurance plans have a deductible that patients must meet before the insurance plan kicks in, and many also have co-pays or co-insurance, in which the patient pays a fixed amount or a share of the bill. Generally, when care is more expensive to the patients, they use less of it. This can be a good thing when the care is discretionary, but for services that are preventive or essential, reduced care can result in worse health. Many insurance companies cover preventive services before the deductible (now mandatory under PPACA). Insurance companies and employers are experimenting with **value based insurance plans**, in which essential services are covered at a higher level (less out of pocket cost for the patient) than discretionary services.

**Provider profiling** efforts uses examination of claims data to identify average rates of service use. Through these profiles, insurance plans can create profiles for general doctors and specialists (who would be expected to use more of certain types of services). Plans will often consult with providers who appear to have practice patterns far outside the norms.

**New with PPACA:** PPACA has a number of provisions designed to “align incentives” so that providers, hospitals and patients all benefit when care is provided efficiently and effectively. ACOs are an important piece of this effort. In addition, CMS is moving to pay for quality and may pay a premium for well coordinated care.
As the national organization exclusively representing PPO health plans and networks, AAPPO believes that PPOs offer the choice and flexibility in care that consumers need. PPOs participate in all varieties of self-insured and fully insured arrangements.

2.0 PPO Characteristics

The AAPPO defines a preferred provider organization as:

A health care delivery system through which providers contract to offer medical services to health plan enrollees on a fee-for-service basis at various reimbursement levels in return for faster claims payment and more patients. Enrollees may use any provider in the PPO or outside the PPO, but have a financial incentive – for example, lower coinsurance payments – to use providers within the PPO. A defining characteristic of PPOs is providing easy access anywhere to the enrollee’s choice of providers for quality care at a fair price.

The PPO health care delivery system is distinguished from other health care models:

- PPOs provide access to the patient’s choice of providers for quality care at a fair price.
- PPOs put control in the hands of the physician and patient, empowering both and resulting in trust, quality and confidence, thereby solidifying long-term relationships.
- PPOs allow patients to choose their providers.

PPOs typically include a wide range of providers so that patients rarely have to seek care from out-of-network providers. These providers include hospitals, physicians and ancillary providers. A PPO network can also be created for a single type of service such as workers' compensation care or a single type of provider, such as chiropractic. In any model, the participating providers agree to a specified fee arrangement; patients will get better insurance coverage for seeking care from an in-network provider.

All PPOs have one thing in common – a network of health care providers who have agreed to provide care to the PPO’s patients, subject to contractually established reimbursement levels. Beyond that, PPOs can be broken down into two categories, those that bear insurance risk and those that do not. A full risk PPO is an insurance company with a designated network of providers. A non-risk PPO offers just a network of providers without the risk-bearing insurance function. The network contracts with insurers, employers or TPAs, which pay or process claims according to the negotiated agreement.

PPOs are organized in a variety of ways. A risk-bearing PPO may provide many services similar to those of an HMO, including managing benefits, paying claims and offering a provider network. Other network-only PPOs may simply provide a contracted network to a customer, which might be an insurer, TPA or self-insured employer. The PPO network customer thus purchases rights to the discounted rates the PPO negotiated with providers. Most PPOs are owned by insurance companies. Hospitals, hospital consortiums, individual entrepreneurs and private equity groups also own PPOs.
Chapter 2 – Preferred Provider Organizations

2.1 PPO Services

PPOs offer an array of services that they mix and match to respond to the preferences of each of their customers. A wide range of PPO service functions is listed below. The core product PPOs offer to employers and other primary customers is access to health care providers, while generating cost savings. At the most basic level, a PPO’s success is dictated by its ability to provide the following:

- Significant discounts from physicians, hospitals and other health care providers
- Comprehensive access to a network of providers
- Control and oversight of patient care based on the needs of the PPO’s customer

Network services that may be offered by PPO companies include:

- **Core Network Services (Always)**
  The core network is typically a group of providers that have agreed to accept covered lives from the PPO or its payer. In return for faster claims payment and the volume of patients, the participating providers agree to discount their normal and customary charges. The production of a provider directory, either in printed or electronic form, is a common business practice of core network services.

- **Expanded or Specialized Networks (Common)**
  PPOs often mix and match networks, depending on the needs of clients and their covered populations. For example, a PPO could expand the scope and breadth of its network by leasing networks from other PPOs. A PPO might also augment a certain provider specialty type within its network to meet the health care needs of the covered population. Some PPOs are made up exclusively of specialty providers such as chiropractors or behavioral health specialists, and may be leased to a health plan or administrative entity.

- **Leasing Network (Common)**
  As referenced above, another PPO service function is leasing its network to another PPO, TPA, insurance company, HMO or employer.

**Operational and Financial Services**

- **Claims Repricing (Common)**
  As part of their primary discounting function, many PPOs can reprice claims to reflect a discounted arrangement. Sometimes this is done internally by the PPO in conjunction with a complete health plan offering. In other cases, the PPO leases or sells access to its proprietary software to an outside party, such as another PPO, TPA, HMO or insurance carrier, to allow the outside party to reprice claims.

- **Claims Processing (Common)**
  Many PPOs provide claims processing services. For example, when a patient sees a physician, the physician generates a bill or claim for the office visit and treatment rendered. A PPO that provides claims processing services would process, and sometimes even pay, the claim on behalf of a payer, such as a self-funded employer or insurance carrier.

- **Cost Sharing (Common)**
  PPOs typically require co-payments, deductibles and certain coinsurance rates to be paid by patients. A patient who uses services outside the PPO’s network pays more.

**Medical Management Services**
• **Utilization Management, Case Management and Disease Management (Sometimes)**
  These programs are discussed more extensively in the next section of this Primer.

• **Pharmacy Benefit Services (Common)**
  As PPOs attempt to reduce health care costs and offer more services, they are beginning to offer or collaborate with managed pharmacy programs. Pharmacy benefit management (PBM) organizations specialize in using volume to secure discounted pharmaceutical products and contracting with pharmacies or mail order companies to dispense prescribed medications. Some PPOs offer their own PBM services, while others collaborate with another organization contracted by the payer.

• **Quality Reporting (Sometimes)**
  Some PPOs provide performance-based or quality information using standardized tools such as Healthcare Effectiveness Data and Information Set (HEDIS) or Consumer Assessment of Health Plans Survey (CAHPS). These reports are usually provided to specific customers so they can examine the data that the PPO uses to determine the quality of providers.

Many PPO clients take advantage of the array of available PPO services by mixing and matching to meet their particular needs. In addition, many PPOs are on the cutting edge of new types of health care services and technologies and are developing better systems to pay claims electronically.
2.3 PPO Revenue Sources

This section covers various ways that PPOs finance health care coverage, including how their customers pay them. First, the focus is on non-risk revenue sources. Second, various payment methodologies are examined whereby the PPO assumes some level of risk. Remember, PPOs are sometimes owned by insurance companies and are licensed to assume financial risk in the states in which they operate. PPOs may also operate as TPAs and administer benefit plans for employers.

- **PPO Non-Risk Revenue Sources**
  PPO networks provide a range of services to customers. Typical service offerings include network access, claims repricing, claims processing and adjudication, UM, CM and provider directories. Not every PPO provides all of these services, and some PPOs offer additional services. Some networks allow customers to pick and choose from the service offerings so that the customers can obtain exactly the services they need.

  o **Network Access Fee**
    At a minimum, PPOs charge a network access fee. This fee entitles the customer to use the provider network built and maintained by the PPO and gives the customer access to the pricing arrangements developed by the PPO with its provider network. Network access fees may include claims repricing services, access to the PPO provider directory, and other services that the PPO sells as part of a basic package. Alternatively, these services may be priced and sold separately.

    Network access fees are typically paid in one of two ways. The first method is a fixed access fee payment per employee or per contract holder per month. Payment is typically made only for employees or contract holders residing within the service area of the PPO network. This method of reimbursement gives customers a strong incentive to direct beneficiaries to preferred providers, since the customer pays a fixed amount per employee or per contract holder, whether preferred providers are used or not. As a result, the customer is motivated to distribute directories and educate employees about the enhanced benefits of using PPO providers.

  o **Percentage of Savings**
    The second method of paying access fees is as a percentage of savings. Percentage-of-savings fees are based on the difference between the amount billed by providers for services and the amount that is actually allowed, based on the usual and customary fees specified in the PPO’s contractual agreements with the provider. The advantage of this method is that the customer pays the PPO only after a measurable value has been received. If no beneficiaries use a particular network, then no access fee is due. If utilization of the PPO network is high but discounts provided through the PPO are very small, then access fees are small. When PPO networks have significant discount arrangements with providers, a percentage-of-savings payment methodology may generate more revenue for the PPO than a fixed-network-access fee payment methodology.

  o **Payments for Specific Services**
    PPO networks may also charge for other services they are asked to provide. These services, discussed above, include utilization management, case management, provider directories, repricing services and claims administration services.

- **PPO Risk Revenue Sources – Premiums and Performance Contracts**
  PPOs that assume financial risk have the same revenue sources as PPOs that do not assume financial risk.
financial risk. A variety of scenarios result when a PPO assumes financial risk. Some of the most common ones are outlined below.

- **Premium**
  Depending on the contract arrangements between the insurance company and the payer, the PPO insurance company assumes a defined level of risk (e.g., that claims experience will not be higher than originally predicted in the premiums charged.) If claims experience is higher than the premium revenue, the PPO insurance company will suffer a loss.

- **Performance Guarantees**
  The clients of PPOs providing TPA services (also called administrative services only, or ASO) will often request that the administrator of the plan adhere to certain minimum service levels. If the administrator does not meet the service expectations, a portion of the fees is refunded to the PPO client. Service levels may include claims payment timeliness, claims payment accuracy and timeliness of answering employee inquiries. If service levels are not met, penalties are imposed and the PPO returns a portion of its administrative fee.

  In addition, a PPO may place a certain amount of the network access or medical management fees at risk. If a predetermined level of savings is not achieved from utilizing network providers, penalties are imposed and a portion of the network access fees may be refunded to the PPO client.

  PPOs may also have contracts under which the PPO receives incentive payments for meeting performance standards. These standards may be based on the total cost of health care services or on exceeding performance standards for administrative services.
PPO Primer for the Public Policy Community

Chapter 2 – Preferred Provider Organizations

2.4 PPO Physician Selection and Interface

PPOs may adopt different goals regarding the size and composition of their provider network. Some PPOs may try to recruit as many providers as possible in a geographic area to participate in the network. Others may limit the number of providers in the network in order to direct greater volume to contracted providers and thus reward them for network participation. A few PPOs will create networks within networks, or tiered networks, based on factors important to those PPOs. Many PPO networks are created exclusively for specialty providers, such as vision or dental care providers.

Any provider who wishes to participate in a PPO network must undergo a “credentialing” process, in which the provider’s education, licensing, board certification and malpractice history are reviewed. Credentialing is a quality control mechanism for the PPO that ensures that only qualified providers participate in the network. Re-credentialing is performed periodically to ensure that providers remain in good standing with state licensing boards.

Because providers may participate in many PPO and HMO networks, they may have to undergo credentialing more than once. Several initiatives are under way to streamline the credentialing process by developing standardized terminology, forms and databases.

Administrative Simplification

It is important for providers that their transactions with PPOs are implemented promptly and efficiently. A primary concern is the management of claims and correct payment of claims. The movement towards electronic claims submission and electronic funds transfer (EFT) has improved claims turnaround time significantly. PPOs typically report on claims turnaround and claims accuracy as a performance metric to payers.

With the implementation of HSA and CDHP products, patients became responsible for greater financial responsibility for health care services. The first several hundred dollars of fees in these plans is the responsibility of the patient. Providers often need to collect variable and often higher payments than would be required under a simple co-pay insurance product. These payments must be collected directly from the patient rather than billed to the insurance company.

These product changes have increased provider’s need to know what insurance the patient has, what financial obligation the patient has, and where to send bills for the balance. To ensure that physicians understand the patient’s insurance coverage and know where to bill the services, and to help patient seek care from in-network providers, it is important that both patients and providers know how to verify network participation. Typically the patient identification card (ID) includes information on which insurance company and network is the “primary network.” Sometimes, however the ID card does not include network information or the provider needs to verify coverage and determine co-payment amounts.

The industry is increasingly working towards the capability of electronic verification (such as a credit card swipe technology) to simplify transactions. As described earlier, use of electronic information sharing and simplification of administrative transactions is viewed as essential to increasing efficiency in the health care system.
Chapter 3 – Health Care and Quality Management in PPOs

3.0 Health Care Management

Health care management is a loosely defined term that includes activities designed to improve quality of care and outcomes for patients. In a PPO setting, health care management includes programs for managing overall clinical quality and targeted programs for managing selected patients. Specialized health care management services are often provided within a specialty health network. Specialty health networks include workers’ compensation, behavioral health and alternative medicine.

A variety of health plan programs affect health care quality. Health care management programs are those that “touch” the member and improve the quality of care provided to that member. Network management strategies such as credentialing and selective contracting, although they do influence quality, are not addressed extensively here. Most PPOs have “medical management” programs in place to improve the quality of clinical care delivered through the PPO system.

Although physicians and hospitals deliver care, medical management programs such as the ones listed below allow the PPO to influence how care is delivered.

- Quality management programs
- Utilization management (pre-certification, concurrent review and discharge planning)
- Case management
- Disease management
- Health and wellness programs, including health call centers, Internet-based programs and worksite prevention programs
- Specialized medical management, including behavioral health, workers’ compensation medical management and complementary or alternative medicine

PPO medical management programs support the direct care relationship between patients and providers and help to ensure that care is medically necessary and appropriate.
3.1 Components of Health Care Management

Full-risk PPOs tend to include medical management programs in the standard package offered to purchasers, while non-risk PPOs offer each medical management service as an add-on to the basic network package.

Accreditation: Several independent organizations will certify quality of HMO and PPO plans. NCQA and URAC both offer accreditation programs for health plans and specialty health networks. Over the years, accreditation standards have been ratcheted up. Standards address both quality of operations (policies and procedures of the organization, credentialing, customer services) and the quality of health care. Accreditation standards typically require that health plans have rigorous programs for consumer protections, and that they follow protocols for appeals related to benefits.

NCQA fields a standardized set of "performance measures" called HEDIS, which requires health plans to report on the quality of care delivered by providers in the network. The philosophy underlying these requirements is that health plans can exert leverage over providers as the bill payer, and can encourage providers to deliver the best care.

Quality management: Quality management programs are almost always internal to the PPO. Every program area of the PPO—contracting, customer service, administration and medical management—generally has a process for overseeing the quality of the service delivered. Often, PPOs create a quality management committee or assign quality management responsibilities to some other committee. Oversight responsibilities in quality management programs are often divided into two key parts: administrative quality and clinical quality. Administrative quality programs are designed to increase efficiency and accuracy of transactions, for example, by tracking and improving accuracy of provider payments. Clinical quality programs are intended to ensure that preventive and treatment health care services are delivered effectively to patients who need them.

Utilization management (UM): UM is a process by which health care services recommended by physicians are reviewed against criteria to determine whether they are medically necessary. Reviews are conducted before care (pre-certification), during the course of a hospital stay (concurrent review), at the time of discharge (discharge planning) and after the episode of care (retrospective review).

Virtually all payers offer benefits only for services considered to be medically necessary. The utilization review process evaluates a requested service in light of the PPO’s medical policy and according to guidelines for appropriate care and makes a "determination" or "certification" about coverage. Patients may still obtain a service that has not been certified, but the PPO may not pay for it if it is determined not medically necessary. Review criteria and staff are specialized for general health, behavioral health, workers’ compensation and alternative medicine.

New in PPACA: Patients not satisfied with the UM decision have always had the right to appeal the decision to a higher level. PPACA includes provisions that create uniform rights to appeal both inside the organization and to seek an external appeal from an independent firm.

Case management (CM): CM is a process used to coordinate care and manage costs of individuals with intense needs or complex medical cases. Individual case managers, usually nurses, provide telephonic or on-site management of cases to ensure that equipment, medications, additional care services and specialty care are coordinated for the patient. CM is often provided to patients with catastrophic illnesses and to high-risk/high-needs infants. Case managers are often called upon to negotiate rates with out-of-network providers and frequently provide the patient care management services that are part of DM
programs. While case management has typically been provided by the health insurance plan, the new delivery models of ACO and PCMH put the care coordination responsibility at the provider level, and may change the way case management is delivered in the future.

**Disease management (DM):** DM is a service that targets individuals with specific diagnoses to ensure that they receive treatment according to the best scientific evidence. DM is evolving towards a broader focus that includes all of the conditions of the patient and concern for the entire enrolled population of a health plan. It is now often referred to as “Population health.”

DM programs use “evidence-based guidelines” as the standard of treatment. Through telephonic, Web-based or on-site coaching of patients and health care providers, these programs ensure that clinical monitoring and therapy are provided according to the standard of treatment. DM programs are usually chosen by the payer based on the prevalence of the disease and the cost of treating the disease and its complications. Diabetes, heart disease, asthma and depression are common illnesses that should be treated according to guidelines and can be very costly if not treated properly. DM programs help ensure that both physicians and patients understand and adhere to evidence-based practices.

**Behavioral health:** Primary care practitioners in a PPO network carry out many behavioral health interventions. Many PPOs, however, have specialized behavioral health networks or list behavioral health providers in a distinct panel. Ensuring that these networks interface is part of the behavioral health management program. Behavioral health programs operate as parallel networks to general health PPOs. They often have separate quality management and medical management programs that monitor the specific indicators for quality of behavioral health programs and use distinct behavioral health medical management review criteria.

**Telephone triage and web-based health information:** Telephone triage (also called health call centers or nurse advice lines) is an enhanced service that can be offered by the PPO or through a vendor contract. The goal of triage programs and health information programs is to provide health advice and reduce demand for acute care services. Triage services offer telephone advice to patients 24 hours a day, 7 days a week. Purchasers expect triage services to reduce costs of emergency room and doctor's office visits by providing personal advice and reassurance. Triage services are also expected to enhance patient satisfaction by facilitating contact with a clinical professional 24 hours a day. Web-based programs offer more general advice but can also provide “decision support” for patients who are facing clinical decisions.

**Wellness and prevention programs:** Many PPOs are adding wellness programs as both a cost avoidance strategy and a member retention service. Wellness programs provide health assessments, advice, counseling and discounted lifestyle products such as gym membership in order to promote good health. While it is difficult to pinpoint the cost savings that can be attributed directly to wellness programs, they do improve member satisfaction. Many wellness programs use a Health Risk Assessment completed by the patient to identify members in need of services. The HRA cannot be used to make insurance decisions, but it is very helpful once members have been enrolled to help them get the lifestyle and disease management programs they need.

**Pharmacy benefits management:** Payers often determine which types and brands of pharmaceuticals are covered, the amount that may be dispensed and the cost to the patient. PPOs may offer a network of pharmacies to dispense medications or may collaborate with pharmacy benefit management companies (PBMs) to manage patient care. PBMs are responsible for overseeing the quality of pharmaceutical care as well as managing pharmacy claims according to benefit requirements. The availability of pharmaceuticals affects other health care management programs, particularly DM.
Chapter 3 – Health Care and Quality Management in PPOs

3.3 PPO Quality Indicators

Quality indicators are measures of performance established by the PPO to ensure that customers’ and consumers’ expectations are met. Some indicators are routinely monitored in the course of business operations. These indicators include complaint rates, network access indicators and patient satisfaction levels. Other indicators may be selected on the basis of the PPO’s operating model, customer demand, troubleshooting or other management needs. This section discusses types of performance measures used to evaluate health care management, sources of data, and statistical and measurement issues to consider in evaluating the quality of health care management.

Quality measurement efforts target three types of indicators (also called measures):

- **Structure**: These measures indicate how the PPO is set up. Structural measures include number of providers in the network, certifications of providers in the network and ratio of customer service representatives to enrollees.

- **Process**: These are measures of activities that are presumed to affect quality. Administrative process measures include claims processing times, credentialing times and customer service response times. Clinical process measures examine how services such as mammograms, immunizations and other treatments are delivered. (A process measure does not provide information about an outcome. For example, a measure of how frequently mammograms are delivered to eligible populations does not provide information on effectiveness of treating any breast cancers that were identified.)

- **Outcomes**: These measures indicate the effect that the structure and process of the organization have had on the cost or clinical quality within the network. Cost outcomes include claims paid, discounts and administrative costs. Cost outcomes are routinely reported by PPOs. Clinical outcome measures would address how effective treatment was in improving health.

Clinical quality is more complex and difficult to measure, because most clinical events continue over the long term and are difficult to quantify in a given period. Examples of clinical outcomes include mortality after cardiac bypass surgery and renal failure in diabetic patients. Hospital mortality and 30-/60-day mortality after surgery can be measured. Renal failure may take years to develop, however, and it is not always clear whether or when a quality failure occurred.

Structure and process measures are often called administrative measures because they can be obtained from administrative data such as claims and enrollment. These measures provide useful information about the efficiency and effectiveness of the PPO’s operations. Common structure and process indicators monitored by PPOs include the following:

- **Customer service**, including
  - Timeliness of enrollment activities
  - Response to telephone inquiries regarding network, enrollment or other questions
  - Response to complaints by patients, providers or payer-customers

- **Network management**, including
  - Efficiency and completeness of contracting
  - Efficiency and completeness of credentialing
  - Network size and adequacy, often measured by the use of out-of-network services
  - Continuous quality monitoring of the provider community
  - Effective communication with providers

- **Claims management** (if this is a responsibility of the PPO), including
  - Repricing accuracy and timeliness
- Claims payment accuracy and timeliness
- Medical management, including
  - Staff efficiency measures
  - Accuracy measures—adherence to clinical guidelines
  - Utilization indicators, including rates of usage and length of stay
  - Effectiveness measures such as cost savings
- Cost measures relating to health care management and network management services
- HEDIS measures
- CAHPS member survey

Still, the ultimate goal for measuring performance is outcomes measures. Providers and plans want to measure, “Did the patient actually get well?” Recent measurement efforts have looked at how well physicians and hospitals are doing at treating an “episode of care,” and preventing future costs by treating an illness well. Many health plans measure “preventable rehospitalization” as an indicator of potentially avoidable costs.

**Accreditation and Quality**

Health plans that are accredited by an independent organization such as the National Committee for Quality Assurance (NCQA) or URAC are required to report performance measures specified by those organizations. NCQA requires health plans to report HEDIS measures and to survey members based on the standard CAHPS survey. The results of these measurements are factored into accreditation certificates of the organization. An organization that does not perform well on HEDIS clinical process and outcome measures and the CAHPS survey cannot receive the highest level of accreditation and may be denied accreditation altogether.

**Linking Quality to Payment**

CMS and many health plans have now aggressively moved to link hospital payment to certain quality indicators. CMS and most health plans now refuse to pay for serious hospital mistakes (called ‘never events) such as operating on the wrong person or the wrong surgical site. In addition, many are refusing to pay more for care when a patient suffers a preventable condition in the hospital such as a hospital acquired infection or injury. Previously even if a problem was caused by the hospital, CMS or the insurer would pay for treatment of the consequences. Now payers are refusing to cover those added costs and prohibit the hospital from billing the patient. This creates a strong incentive for the hospital to develop systems and processes that prevent programs.
Chapter 4 – Definition of Terms

4.0 Definition of Terms

Appeal: the right of a consumer to ask for an independent review of a decision made by a health plan. The appeal can pertain either to whether a service is covered under the insurance contract, or to a UM decision regarding whether the services is medically necessary. PPACA gives consumers additional rights to appeal.

Actuary: a professional in the health insurance industry who uses statistical information and mathematical models to assess insurance risks. Insurance companies are required to have "actuarial soundness," which means demonstrating that they have considered how much money they may need to pay out for all health care an non-health expenses, and have that amount plus reserves on hand.

Authorization: a UM term indicating that the request for service has been reviewed against medical necessity criteria and has been authorized for payment.

Broker/Consultant: brokers typically assist individuals and small groups in identifying and comparing insurance products, while consultants often advise large groups and large employers on plan design and cost management. Brokers are often paid a commission by the insurance company selected, while consultants are typically paid by the employer customer.

CAHPS: A survey developed by the federal Agency for Healthcare Research and Quality that is now used to evaluate patient experiences with physicians, hospitals and health plans. It is used by NCQA in accreditation of PPOs and HMOS.

Capitation: an insurance arrangement in which a pre-arranged fee is paid to a provider in anticipation that the provider will cover all needed services. Some insurances “partially capitate,” which means providers accept risk for some services but not all (such as hospitalization).

Covered services: the services that will be reimbursed under the insurance plan. Most medical insurance plans cover physician and hospital services for medical and behavioral care. Services that are not always covered are dental and vision, wellness, home health and other ancillary services.

Claim: A claim is a request for payment by a health care providers. Claims typically include coded information about the diagnosis and the procedures carried out and a National Provider Identifier (NPI) indicating which provider delivered the services. In addition to being vital for payment, claims are often used to evaluate quality and volume of services. Formerly a paper-based transaction, claims are increasingly transmitted and paid electronically, a major efficiency for both insurers and provider.

Co-insurance: the patient’s portion of a bill after the insurance payer has determined the allowed amount. The patient may also be responsible for paying the difference between the allowed amount determined by the insurance payer and the fee charged by the provider.

Consumer directed health plan: a relatively new product in which the covered beneficiary is expected to be more involved in health care decision making and purchasing than under an ordinary policy. Consumers have a tax-advantaged health savings account and a high deductible plan – often PPO based. The consumer controls spending for the first dollars (the amount determined by the plan sponsor and after mandated zero copay preventive services), after which a more traditional insurance arrangement kicks in. Consumers with CDHPs are expected to become more informed about comparative health care costs and treatment options.
Co-pay: the fixed per-visit fee that the patient pays for primary, specialty and emergency care.

Credentialing: the process of checking the providers license and education and malpractice history to ensure they are valid as represented by the provider.

Deductibles are the amounts of the covered expenses the patient must pay each year before the insurer provides any reimbursement. They might range from $100 to $500 per year per individual, or $1,000 or more per family. Generally, the higher the deductible, the lower the premiums charged by the insurer to the patient. Premiums are the periodic payments for the insurance. Higher deductible plans are becoming more popular, including Health Savings Accounts. These deductibles often range from $1,000 up to $3,000 or more per person per year.

Denial: a UM term indicating that the requested service or benefit did not meet the criteria as medically necessary or was not a covered benefit. For example, cosmetic procedures may be denied insurance coverage because they are not covered benefits. The consumer can appeal a denial of benefits.

Evidence based care/ guidelines: UM decisions and most clinical quality programs of PPOs are designed to ensure that patients receive care that is consistent with professional recommendations and evidence from medical research. Evidence based care is the process of assuring that patients get the care recommended by professionals and don’t get care that will not help, is harmful or is not indicated for their condition. Evidence based care can both control costs by reducing unnecessary care, and increase quality by ensuring delivery of important services.

Electronic data interchange: the process of transmitting health information and claims electronically. EDI increases efficiency of payments, health plan administration and quality management.

Exchange: A virtual or real marketplace where consumers can shop for insurance products and compare options. Exchanges as defined by PPACA have minimum standards set for the health plan products that can be offered.

Exclusion: A health plan may legally exclude coverage for certain services under plan coverage as long as information about the exclusion is provided to enrollees in benefit plan information and is applied to all people in that plan. Under PPACA plans may not exclude certain services just for selected individuals, e.g. a plan cannot exclude care of heart disease for a patient enrolling in the plan with a preexisting condition of heart disease.

Fee-for-service: Fee for service is the method of paying for health care services as they occur. Insurance companies and plans may negotiate discounts on fee for service or bundle services that will be paid for together. The major alternative to fee for service is capitation. Case rates and episode of care payments are less common alternatives.

Health maintenance organization (HMO): a prepaid, network-based health care plan that is licensed by each state and has a contractual relationship with health care providers. HMOs assume financial risk for the cost of medical services and may share risk with providers. Traditional HMOs do not pay for services of non-contracted providers. Many HMOs now pay part of out-of-network provider fees or offer a POS plan as part of the HMO offering.

Health savings account (HSA): a tax advantaged savings vehicle often funded by an employer but owned by the employee or beneficiary. Funds can be used to pay for health expenses or rolled over as an health care spending investment vehicle the employee. HSAs were created to increase price awareness on the part of the consumer. (A Flex Spending Account (FSA) is similar but the dollars are contributed by the employee and must be spent each year, rather than accruing to the owner.)
**HEDIS:** NCQA's Healthcare Effectiveness Data and Information Set, a set of performance measures that are produced by health plans using a “recipe” or standard protocol so that all plans can be compared on the same set of measures. HEDIS measures address both health care processes and some efficiency metrics. Plans are expected to use the information provided by HEDIS measures to leverage their influence with hospitals and providers to encourage those entities to improve performance.

**ICD9 and ICD10:** All claims include a code that classifies the patient condition using the standard terminology of the International Classification of Disease (ICD). The US is moving from the ICD-9 to the next generation of classifications, the ICD-10. ICD-10 will allow for vastly more information to be transmitted in a coded format, but also requires expensive retooling of physician billing practices and insurance claims-paying systems.

**Indemnity plan:** health insurance that pays for covered services on a fee-for-service basis. An indemnity insurance plan may use a fee schedule to determine the amount that will be paid for a service. Indemnity coverage usually allows the physician or hospital to charge the patient the difference between the provider’s billed charge and the amount the fee schedule will allow for the service.

**Insurance:** coverage by contract whereby one party (the insurance company) undertakes to indemnify or guarantee another (the contract holder or patient) against loss by a specified contingency (the cost of care for injury, illness and routine care). Insurance transfers financial risk from an individual to the insurance organization, which pools the risk to reduce the potential for financial loss.

**Integration:** a term used to describe the ability of providers and information systems to seamlessly coordinate care of a patient across the spectrum of health care needs.

**Lifetime limits** – Prior to PPACA some plans imposed a lifetime limit on the amount of benefit that could be paid under the policy. Plans may still have an annual limit (to prevent insolvency) but may not have a lifetime limit. Plans may purchase catastrophic reinsurance to mitigate their risk for these high dollar claims.

**Medical loss ratio:** the ratio of clinical expenses compared to administrative expenses of an insurance plan. PPACA imposed restrictions requiring that plans meet at least a specified percentage of MLR. MLR requirements were intended to ensure that plan expenses are kept low but may adversely impact some specialized plans and plans with products in small groups, which may be more costly to administer.

**Medical management:** a term that includes utilization management (preauthorization of non-emergency hospital care, such as elective surgery), case management (management of serious inpatient cases, such as cancer) and disease management (inpatient and outpatient programs to help patients manage chronic diseases, such as diabetes).

**Medical necessity:** a term used by health plans to indicate that according to the best available science and professional recommendation, a service or treatment is medically appropriate for the condition under care.

**National Provider Identifier:** a unique identification code required from all providers. Enables insurers to process claims efficiently and track quality of care.

**Network:** providers and facilities that have agreed to participate in a billing arrangement and sometimes, to meet quality or other standards included in the contract. Most networks are based on credentialing of providers and include a discount off of billed charges. Patients pay less out of pocket for visiting in-network providers.
Out of pocket: the amount paid by the patient for coinsurance, deductibles and non-covered services. Health Insurance policies usually have co-insurance and deductibles that are paid by the patient and out-of-pocket maximum patient payment limits, which protect the patient in case of serious illness or injury. Out-of-pocket amounts generally do not include the patient's share of the insurance premium.

Pharmacy benefit management (PBM): a specialized firm, either stand-alone or a part of a health plan, that negotiates pricing with pharmaceutical vendors and administers a prescription drug benefits. The PBM often includes a mail order service and a pharmacy network consisting of retail pharmacies.

Point of service (POS): plans that combine features of HMOs and PPOs. They offer an open-panel network platform, meaning that the patient has the option to stay in-network or go out-of-network for care, with different amounts of coverage for those choices. Typically, a referral from the patient's primary care physician is not required.

Preferred provider organization (PPO): a health care delivery system through which providers contract to offer medical services to health plan enrollees on a fee-for-service basis at various reimbursement levels in return for more patients or faster claims payment. Covered persons may use any provider in the PPO network or outside the PPO network, but they have a financial incentive to use providers within the PPO network. PPO-contracted providers agree not to bill patients the difference between their charge and the charge on the PPO’s fee schedule.

Premium setting / rate setting: health insurance companies develop rates using information about employees and their dependents, including age, gender, average family size, local medical costs and the industry in which they work.

Purchasers (payers): The term used to describe the organization paying for insurance or sponsoring a health plan in order to pool risk most effectively. The United States has many purchasers, including employers; federal, state and local governments; trade associations and individuals.

Re-pricing: an administrative process carried out either by an insurance plan (PPO, POS, HMO) or a stand-alone vendor. Re-pricing involves taking the bill (claim) submitted by a provider and applying any contractually approved discount previously negotiated by the plan. “Billed charges” are the retail amount on the claim, while “paid claims” reflect the actual amount paid by the insurer after the discount.

Self-Insured / Self-Funded: when an employer assumes the financial risk of health care claims costs directly it is called self-funding. This means the employer seeks a business relationship with a third party administrator (TPA) or administrative services organization (ASO) to provide administrative services.

Underwriting the process of evaluating health insurance risks for a specific individual or group, for the purpose of accepting that person/group for coverage and determining the price of coverage.

Some terms adapted from 1999 Guide to Health Insurance, the Health Insurance Association of America (now AHIP)