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Chapter One: Introduction to Managed Care

Managed care has become a popular system for paying, delivering and coordinating health services in America. Its roots are in the powerful railroad, mining and lumber industries in the 1800's and today it is now used by more than half the US population. This course will discuss the formation of the large and influential managed care industry, the structure of the many forms of managed care systems available, the types of provisions most commonly found in managed care arrangements and the challenges the industry faces today.

Managed Care Defined



The term *managed care* refers to any health delivery system that includes the utilization of a network of providers and the process of overseeing the types of care and services provided by the physicians and other parties supplying health care inside of the network.

Health care services offered through managed care programs differ from those offered outside of managed care networks in some significant ways. First of all, managed care is intended to focus on prevention of sickness rather than on focusing primarily on delivering health care services to those who are sick. Prevention is encouraged and made a priority for the patient because managed care plans generally pay on a 100% basis for immunizations and well-patient

examinations. Also, the compensation of physicians working within a managed care network often results in physicians earning more if patients stay healthy, or require less care, than if patients need a lot of sick care.

Under traditional methods of providing health care services, physicians and other health care providers earn money for treating sick patients – every office visit and treatment given results in another fee for the physician. This traditional method of giving health care is known as *fee-for-service* care. Under fee-for-service arrangements, every time a physician provides a service, the physician is paid a fee.

Another way managed care differs from fee-for-service arrangements is that managed care focuses on providing *primary care*. The types of care considered *primary care* do not necessarily fit into a neat description, but generally means care that one would normally get from a non-specialist. Care received from a specialist is generally more expensive than care provided by a family practitioner, gynecologist, pediatrician and the like. Therefore, if more care is provided by a primary care physician, the plan and its members should experience reduced costs. In a managed care network, physicians who provide primary care are encouraged to try to provide all the care they reasonably and appropriately can before suggesting a patient go to a specialist.

When reading this short description of managed care, concerns may have already begun to arise in the mind of the reader. If physicians are given incentives to limit care and not refer a patient to specialists, don't circumstances arise when a sick patient is not given the care needed? This is certainly an important concern surrounding managed care as it is practiced today. Another criticism levied against managed care is that non-health care personnel, in some cases a for-profit corporation, are often in charge of overseeing what kind of care is given to a patient. This raises the concern that profits are emphasized over necessary care.

Even though these concerns are being important to and being discussed by regulators and the public today, the managed care industry is booming. There are many reasons for its popularity. Knowledge of its history, including the problems managed care was created to respond to, makes the popularity of managed care services easier to understand.

History of Managed Care

Managed Care in the Nineteenth Century

The first form of managed care arose in the nineteenth century, as part of the industrial revolution. In the railroad, mining and lumber industries, corporations responded to the challenges of high accident rates and resulting lawsuits in part by contracting for medical services, purchasing hospitals or creating dispensaries on their own property to handle the health care needs of workers. The physicians worked for the corporations on a contract basis or were salaried employees.

Managed Care at the Turn of the Century

The practice of contracting with physicians to provide health care spread from the large railroad, mining and lumber businesses to many smaller businesses by the late 19th century and early 20th centuries. By this time, many small to mid-size businesses were offering health care services to employees. Some firms contracted with physicians and insurers to offer a full spectrum of health coverage to employees and their families. Other firms contracted with physicians to care for employees injured on the job.

Blue Shield plans originated in this time period. Employers in the lumber and mining industries began to make contractual arrangements with physicians to provide medical care for workers. These physicians were paid a monthly fee. Eventually, groups of physicians who provided these services were formed and called *medical service bureaus*. The first of these medical service bureaus was formed in 1917 and today operates as a Blue Shield plan.

Corporations were not the only entities sponsoring health care programs at the turn of the century. Fraternal organizations, such as The Moose, also contracted with health care providers. Generally, a flat fee was paid on a per member basis and comprehensive care was provided. Health care offered through fraternal organizations was even more common than health care offered through corporations.

Local governments also began contracting for health care services for employees, prisoners and lower-income citizens about this time. Branches of the military also contracted with health care providers.

The practice of contracting with physicians or hospitals for health care was not without its opponents. Because fees for service were discounted for those receiving care through a contractual arrangement, physicians who were independent of these contractual relationships had a hard time competing. Many physicians, inside and outside of contract medicine, were uncomfortable with the fact that the terms of contracts governing health care services resulted in limiting how and what care the contracted physicians could prescribe.

Over time, interest groups on both sides of the issue investigated contract medicine. Eventually, the medical community put pressure on hospitals and physicians to view contract medicine and those who practiced it in a largely negative light. Laws were passed in many states that disallowed the practice of corporations drawing up contracts for medical services under the reasoning that through such contractual arrangements, non-physicians (the corporations) were practicing medicine. Insurers and fraternal organizations began moving away from contracting with physicians to offer specified services and instead put together programs to reimburse members for health care services provided. Reimbursement programs allowed the physicians and hospitals to determine what type of care should be provided to patients. Discouraging contractual arrangements helped keep fees for services at a higher level for the medical community in general.

Managed Care in the '30s and '40s

The Great Depression put pressure on health care providers, especially hospitals, to re-think their stand on contracted medical care. During the depression, physicians were financially harmed because patients could not pay their bills. Having a large corporation or other sponsoring organization pay a per member fee for medical care began to seem like a more financially secure arrangement than relying on individual payers for many physicians in the health care profession.

At about this time, Blue Cross was developed. Blue Cross plans covered the cost of hospital care through pre-paid hospitalization arrangements. Blue Cross's pre-paid hospitalization plans began in 1929 when a contract to provide 21 days of hospital care for \$6 was introduced to teachers at Baylor University in Dallas. Physician's services were not part of the plan, thereby leaving intact physician control over patient care. Medical community opposition to the plan did not impede the ability of this type of plan to be implemented throughout the country.

Managed Care in the Sixties

The fee-for-service structure for health care insurance plans and corporate sponsored medical care plans remained generally in place until the 1960's and 1970's. Health care costs increased greatly during this period. The medical profession was accused of performing unnecessary surgeries and prescribing too many drugs and providing unnecessary medical care. It was also characterized as being made up of too many specialists and not enough general practitioners and other primary care physicians.

Because of the passage of Medicare at this time, the federal government became highly involved in passing legislation regarding health care. Cost containment was a primary focus of this legislation. Research done regarding pricing and services offered by the medical community showed that physicians had differing standards regarding what level and types of care were appropriate. It also showed that physicians charged very different fees for basically the same care. So, Congress ordered additional research to determine what results would occur if alternative care for various illnesses and injuries were given. From all this research came the rules and regulations regarding what kinds of care and services Medicare would cover. As a by-product of the political battles over Medicare and cost containment, employers and the public determined that the costs associated with medical care could and should be contained. The perception that the physician always knew best and could be trusted to provide only needed care at the best price was also significantly changed during these events. A movement for national health care sprang up during this period.

In addition to government's interest in reducing health care costs, private enterprise was also motivated to see health care costs reduced to as low a level as possible. The employment marketplace was putting pressure on employers to provide health care benefits to employees. The public was ready for a new approach to health care distribution.

The Health Maintenance Act of 1973

During the Nixon administration, the Health Maintenance Act of 1973 was signed into law. Under this law, the federal government helped to fund the growth of Health Maintenance Organizations (HMOs) by giving federally collected tax dollars to help HMOs through their start-up periods. HMOs provide a specified set of health care benefits in return for a fee or premium paid on a per member basis. The HMO as defined at this time and continuing through today is involved in arranging for the care of its members; it does not leave the job of deciding what type of care is required solely in the hands of the physician. Rather than reimbursing for care given, most HMOs pay physicians working under the plan a flat fee on a per patient basis. In the 1970's up to today, HMOs are seen as a way to control the escalating costs of health care by requiring physicians to work within set fee schedules. Since HMOs also oversee the care prescribed by physicians, they are seen as a force to eliminate the practice of physicians performing unnecessary surgery and prescribing unneeded drugs or other therapy to patients.

Managed Care in the '80s

Enrollment in HMOs increased dramatically in the 1970's and 1980's. In 1970, there were approximately 3 million members of HMOs in the United States. By 1975, the number of members had doubled and the number of HMOs had increased by five times. Between 1975 and 1983, enrollment in HMOs doubled, and doubled again by 1986.

The reasons for the increase in HMOs during the 1980's include:

- Changes in state regulations that had previously discouraged the use of contract medicine or prepaid plans
- Regulations within OBRA 1981 that provided greater flexibility to states in enrolling Medicaid recipients in Medicaid
- Regulations within TEFRA 1982 that inaugurated the Medicare risk-contracting program
- Employers' and public's perception that managed care could result in cost containment
- Innovations in HMOs responding to consumer needs for greater choices regarding physicians and hospitals.

In 1981, the Reagan Administration ended the federal assistance portion of the Health Maintenance Act. During the time the federal assistance program was in place, 657 federal grants were awarded, ninety HMOs received direct loans amounting to a total of \$184.6 million and four HMOs received loan guarantees for \$88.7 million.

Managed Care Today

In the 1990's enrollment in HMOs and other managed care systems continued to grow. Part of the growth may have stemmed from the private sector's reaction to the Clinton Administration's failed plan for a national health care program. Over 50% of the US population was enrolled in some kind of managed care program by 1996.

Today, the option of managed care remains popular. However, the industry faces many challenges. Legislators on both state and federal levels continue their interest in health care issues. Recent federal legislation targeted health insurance continuation (COBRA rules), causing increased pressure on insurers to accept high-risk insureds. Additional regulations included the expansion of managed care options for Medicare recipients, meaning increased federal intervention and scrutiny of patient services. The public and the medical community continue their debates regarding the role of the physician in patient care. The industry struggles with attempts at suppressing greed among the players in the managed care field, while at the same time creating compensation packages that motivate these players to provide appropriate services to patients. Continuing change in the industry should be expected as these challenges are faced.

Excerpts From Title 42, Chapter 6A, Subchapter IX, Section 300e – The HMO Act

TITLE 42 – THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A – PUBLIC HEALTH SERVICE
SUBCHAPTER IX – HEALTH MAINTENANCE ORGANIZATION

Sec. 300e. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined.

For purposes of this subchapter, the term "health maintenance organization" means a public or private entity which is organized under the laws of any State and which

- (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and
- 2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members.

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

- (1) Each member is to be provided basic health services for a basic health services payment which

(A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided;

(B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished;

(C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and

(D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section (2) of this title, in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to

benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this subchapter referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 1(2) of this title) ...

(3)

(A) Except as provided in subparagraph (B), at least 90 percent of the services of a physician which are provided as basic health services shall be provided through -

- (i) members of the staff of the health maintenance organization,
- (ii) a medical group (or groups),
- (iii) an individual practice association (or associations),
- (iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or
- (v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician -

- (i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or
- (ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(D) For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a non-metropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition...

(c) Organizational requirements

Each health maintenance organization shall ...

(3)

(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health

maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and

(B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program

(A) stresses health outcomes, and

B) provides review by physicians and other health professionals of the process followed in the provision of health services...

Chapter Two: Managed Care Fundamentals

The managed care industry uses many unique terms. It is important to understand these terms in order to understand the structure of managed care plans.

Important Terms in Managed Care

Capitation

Capitation means to number by the head, and refers to the practice of paying for patient care based on the number of patients under the care of a physician. Under managed care systems, physicians within the network are generally capitated, or paid a flat fee per month, per patient.

Preferred Provider

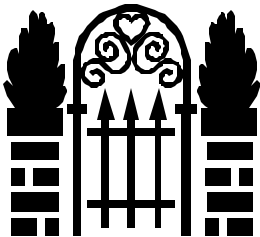
In return for joining a managed care network, providers have the opportunity to increase the number of patients they see. A *preferred provider* is one chosen by the managed care network or managed care sponsor (such as an employer) to provide the health care services outlined in the managed care plan. The services provided by such health care providers are offered on a discounted basis as compared to services from providers outside of the plan.

Primary-Care Physician

Under most managed care plans, each member must select a *primary-care physician*. The primary-care physician gives most of the care to a patient. A primary care physician is typically a family doctor, pediatrician or other non-specialist.

Gatekeeper

One of the most important functions the primary-care physician performs is the role of *gatekeeper* for the managed care organization. Under most plans, the primary-care physician determines when a patient should go to a specialist or should be given certain types of medical tests. Because this physician either opens or closes the door to these services, he or she is called a gatekeeper.



Referral

The method used by a primary-care physician to give permission to a patient within the managed care network to receive medical care not provided by the primary-care physician is known as a *referral*. Under most managed care plans, unless a primary-care physician gives a referral in accordance with the

process required by the plan, if a patient goes to a specialist, the managed care plan will not pay for the care received.

Specialist

A *specialist* is a physician who specializes in an area outside of primary care. The specialist has advanced training in his or her specialty field. During the 60's and 70's, the high-cost of medical care was blamed in part to the large number of doctors who came out of medical school as specialists, giving them the ability to charge higher fees than the general practitioner. Today, specialists may agree to discounted fees in return for receiving additional patients through a managed care system.

Case Management

Under some managed care plans, the overall care of certain patients is subject to oversight and coordination by various health care providers through the process of *case management*. Generally, case management is utilized when a patient needs care from different types of caregivers. For example, a victim of a serious accident may need hospital care, home health care and rehabilitative

care. The managed care plan seeks to provide this care for the most reasonable cost by coordinating the care through the process of case management.

Copayment

A *copayment* is a small amount paid by patients in a managed care system for the services received. For example, a patient may pay \$5 to \$10 each time the patient is seen by the primary-care physician.

Coinsurance

Coinsurance is not generally a requirement under care supplied through a managed care network. Rather, it is used in health plans utilizing fee-for-service payment arrangements. Under such health plans, the plan will pay for 50% to 80% of the cost of health services. The patient must pay for the other 20% to 50%. The amount the patient must pay is called *coinsurance*. Some health plans combine managed care with traditional fee-for-service options. Under such plans, the care given outside of the managed care network is generally subject to coinsurance requirements.

Deductible

A *deductible* is the amount an insured is required to pay before the insurer will pay for a benefit. Managed care plans often do not utilize deductibles; deductibles are found more commonly in plans that reimburse fee-for-service care. For example, a health plan may have a \$250 per-family-member deductible, and once that amount is met, the insurer will begin paying for care.

Health-Maintenance Organization

The name *health-maintenance organization*, or HMO, was created by the Nixon administration when the Health-Maintenance Organization Act was passed. HMOs select the doctors, hospitals and other medical professionals used to care for its members. The HMO authorizes and arranges the care provided to its members. HMOs differ from traditional health insurance plans because the care provided is managed by the HMO, and is not based on the decisions of an individual physician or physicians. Another key difference is that traditional health plans reimburse for care prescribed by a physician and HMOs collect a monthly premium, which along with a copayment, is all the member pays. The physicians within the plan are generally paid by the HMO a flat fee per month for each of the physician's patient under the plan, although a variety of compensation packages are used within HMOs today.

Enrollment Area

Managed care plans generally provide care for residents within a certain geographic area. This geographic area is called the *enrollment area*.

Open Enrollment Period

Managed care plans offered by employers or other sponsors, include a period of time in which a new member may enroll. This period of time is called the *open enrollment period*. Generally, this is the beginning of the plan year, which often coincides with the beginning of the calendar year. People who are newly employed or new members of a sponsoring organization can also generally sign up for the managed care plan at the time of joining the business or sponsoring organization.

Network

Network refers to the physicians, hospitals, clinics, group practices and other health care providers participating in the managed care plan. Care provided within the network is subject to the rules of the plan in order for the plan to pay for the care.

Types of Managed Care

There are a wide variety of managed care plans available today. Many involve HMOs but other types of managed care structures also exist. HMOs are by far the most common form of managed care structure.

Generally, the HMO structure works as follows:

- A person enrolls in the HMO.
- The HMO promises to provide services including routine, preventative, specialty care and hospitalizations in return for a monthly premium or fee which may be paid by the member or may be paid in all or in part by the member's employer.
- The member must generally select a primary-care physician.
- The member pays a small copayment or fee for services provided. No deductible or coinsurance applies.
- Care that is provided outside of the network is either not covered by the HMO or is covered in a manner similar to traditional fee-for-service insurance.

Staff HMOs

Staff model HMOs are one of the oldest forms of HMOs. Under a staff model HMO, the HMO owns and operates the health centers and clinics that provide care under the HMO plan. Physicians who give care to members are salaried employees of the HMO.

Group HMOs

Another early model of HMOs is the *Group HMO*. Under the Group HMO model, health centers are not owned by the HMO. The HMO contracts with one or more medical groups to provide the services within the plan. The physicians within the plan operate as an independent partnership or as professional corporations, separate from the HMO.

Managed Fee-For-Service Plans

Managed fee-for-service plans were an early attempt by insurers to try to control costs by including some oversight of a patient's doctor prior to paying for benefits. These plans had broad conditions, such as requiring a second physician's opinion before certain forms of care would be paid for, limiting the number of days payment would be made for hospitalization for certain conditions, and similar provisions. These plans did result in some cost containment, but have in general been replaced by plans offered through Preferred Provider Organizations.

Preferred Provider Organizations

Preferred Provider Organizations, or PPOs, allow insurers to exercise more control over the physician's care than did managed fee-for-service plans. As under group model HMOs, the physicians within a PPO are not employees of the HMO. Rather, they are physicians who enter into contractual arrangements with the PPO, generally an insurer, to provide services within the plan. The insurer generally includes provisions in the plan which give the insurer the ability to oversee some aspects of the care given by the provider.

Under a PPO arrangement, a member of the PPO chooses a preferred provider from a list issued by the insurer. The insurer pays for a greater percentage of the cost of care given by a preferred provider than care provided by a non-preferred provider. The preferred providers accept lower fees for their services from the insurer because being listed as a preferred provider gives them access to more patients.

Comparison of Managed Care to Traditional Fee-For-Service Health Plans

Managed Care	Fee-For-Service Care
Members receive care from the health care providers within the network.	Patient selects any physician or provider.
Plans include coverage for routine and preventative care, along with care for treatment of illness or accident.	Plan generally covers treatment of illness or accident, not routine or preventative care.
Any necessary care from a Specialist or through a hospital is generally authorized by a primary-care physician and arranged by the HMO.	Although insured may have to notify an insurer in advance of specialty or hospital care, traditional fee-for-service plans do not place restrictions on this care.
Managed care plans generally include no deductible nor coinsurance requirements for care given within the plan's network.	Fee-for-service plans include deductibles and coinsurance requirements.
Managed care plans cover most or all of the care provided within the network, but do not cover care outside of the network.	Under fee-for-service plans there is no <i>inside of network, outside of network</i> issue. All care provided is subject to the same rules contained in the health plan.
Under many managed care structures, the plan arranges for and is responsible for the care given the patient.	Under fee-for-service plans, the physicians and health care providers are responsible for the care given to a patient. The insurer is not involved.
Managed care plans do not involve paperwork for the patient; there are no claims forms.	Under traditional health plans, the physician or patient must complete claims forms in order to receive reimbursement from the insurer.
Premiums are generally lower in managed care plans, particularly HMOs, than under fee-for-service based plans.	Premiums in fee-for-service plans are commonly 20% higher than in HMO plans.

PPOs were popular as an early form of managed care, but lost popularity because some physicians involved in PPOs increased their income by requiring patients to be treated more frequently than necessary and providing expensive treatment during appointments. When such abuse occurred, the insurer and in some cases the employer who commonly paid for these plans, did not experience cost savings but instead saw an increase in health care costs. To avoid the risk of abuse, many insurers stopped offering plans including reimbursement to physicians for services rendered.

Exclusive Provider Organizations

Plans offered through *Exclusive Provider Organizations*, or EPOs, involve a group of physicians and one or more hospital and other medical care providers. The group contracts with an insurer, an employer or other sponsoring organization to provide care. EPO arrangements are similar to PPO arrangements, except that only care received by the EPO is covered by the plan.

Point of Service Plans

Point of Service Plans, or POS plans, are plans that allow for the use of both HMO and non-network providers. They were created in response to members' desire to have greater choice regarding the care they receive. Under a POS, the HMO coverage generally applies only to the care given by a physician who is part of the HMO network, for emergency care, and for approved care from an outside specialist. If care is provided by a non-network provider or outside of the rules of the HMO plan, it is covered by a traditional health plan, involving deductibles and coinsurance requirements.

POS plans meet the needs of consumers who do not want to switch doctors in order to be covered by an employer's health plan or who do not like some other aspect of HMO coverage. POS plans generally have higher premiums than HMO plans, and the coordination of care that occurs under an HMO form of managed care may be more difficult to arrange under a POS, since both network and non-network providers may be involved in the care of a patient.

Independent Practice Associations

The fastest growing form of HMO is the *Independent Practice Association*, or IPA, HMO. A large number of individual practitioners contract with the HMO to provide health care services. These practitioners may have exclusive HMO in certain geographical groups of physicians who offer may have the responsibility of and overseeing the care given Members of the IPA HMO from among the many independent practitioners also



The structure of an IPA is contractual arrangements vary:

- The HMO capitates, or
- The IPA subcapitates, or the primary care
- The IPA deposits the from the HMO in a *risk* to pay for specialists, hospital care and other services.
- Annually, the money left in the risk pool, if any, is shared among the IPA's physicians and the HMO. If a loss occurs, the HMO also has some share in the loss.

generally as follows, although

pays a monthly fee, to the IPA. pays a smaller monthly fee, to physicians within the IPA. remainder of the fees received *pool*. The risk pool is to be used

In some cases, the IPA enters into *full risk contracts* with the HMO, wherein they take a higher fee from the HMO and do not share, or share very little of, the profit with the HMO. Of course, under a full risk contractual arrangement, the IPA also is hit for any losses with little or minimal sharing with the HMO.

IPAs are the fastest growing form of HMO. The number of IPA HMO arrangements grew 35% between 1995 and 1996. It is estimated that over 60% of HMO arrangements are IPAs and eleven of the twenty-five largest individual HMOs are IPA plans.

How Managed Care Plans Reduce Expenses

Managed care plans attempt to provide necessary care to plan members while controlling expenses. Employers, who are the parties who are responsible for making managed care available to most managed care recipients, are interested in keeping health care expenses as low as possible. Managed care members also want to keep their fees and premiums to relatively low levels. Governments, who sponsor plans for people of low-income, for the aged, for government employees and for prisoners, also want low cost health care. Managed care was developed in large part due to demands from the public for low cost health care.

Physician's Compensation

One of the ways managed care plans control expenses is through compensation arrangements with physicians. There are a variety of different compensation plans used. Each one attempts to fairly compensate physicians while maintaining reasonable care standards for members.

Before discussing managed care physician compensation packages, remember that managed care as it developed in the 1970's was responding to many complaints about fee-for-service compensation arrangements. Under fee-for-service arrangements, doctors have a monetary incentive to provide as many health care services as possible. It was believed by some that fee-for-service arrangements were the root of the escalating health costs in the 60's and 70's. Doctors were viewed as money-hungry, as prescribing unneeded care in order to line their own pockets with profits. Many physicians during this time period graduated with their medical degrees in specialty fields, helping to fuel accusations by critically minded observers that graduating medical doctors were greedy and obtained these specialty degrees in order to be able to charge higher fees for their services. Today, the various compensation arrangements in place try to reduce the incentive to provide unnecessary care while not removing the important incentives to providing necessary care. Some arrangements are seen as more successful at meeting these objectives than others.

One method managed care plans use to compensate physicians is to put them on a **salary**. Some salary plans include a small incentive arrangement based on keeping costs down to a certain level. Under such arrangements, the physicians are employees of the managed care organization. It is thought by proponents of this method that salary arrangements reduce the incentive to over prescribe and yet do nothing to discourage the rendering of appropriate care. Detractors of these compensation arrangements point out that the less work a doctor does for his or her salary, the higher the effective salary earned. For example, if two physicians both earn \$200,000 annually and one works sixty hours per week and the other 35 hours per week, the physician working 35 hours per week has effectively been paid more than the physician who worked 60 hours per week. Another criticism of salary plans is that the doctors who accept salary plans are those who cannot "make it" financially under a compensation plan that pays based on being able to attract and keep patients. Detractors of salary plans claim that less qualified doctors are attracted to salary plans because they aren't able to make a living in a practice where their income was based on serving their own patients. Proponents respond that physicians who want to ensure that their patients are not impacted by the physician's ability to grow wealthy are attracted to salary plans.

Another compensation method used is **capitation**, where a physician within the plan is paid a flat fee per member under his or her care. Such plans also include incentives based on meeting financial targets. These incentives may be a large part of the physician's compensation or a relatively small part. Those who favor capitation plus incentive plans believe they are effective at reducing the physician's motivation to over treat, since regardless of the number of times a patient is seen, within target boundaries, the physician is paid the same amount.

Opponents of capitation plus incentive plans say that physicians are given too many incentives to give as little care as possible. There is particularly strong criticism levied against plans under which a physician can earn as much as 50% or more of his or her annual compensation based on meeting financial targets such as keeping referrals to specialists, hospitalization days and specialized testing under certain limits.

A third method of controlling expenses through physician compensation under managed care plan is through **paying physicians on a discounted fee-for-service basis**. Under such arrangements, the physician agrees to receive a discounted amount for the various services provided. These arrangements also generally include a generous amount of oversight authority over the physician's care by the managed care plan. Such plans may include in their provisions oversight committees, written standards of care to be prescribed based on different medical conditions, maximum authorized hospitalization days, etc. Proponents of this type of system like the fact that physicians receive a controlled monetary incentive to provide more care than they believe physicians may provide under capitation systems. Detractors believe that physicians need to have more incentives to reduce unnecessary care.

A fourth type of compensation arrangement is constructed so that **physicians are shareholders** in the managed care plan. As shareholders, the physicians' incomes are based on controlling expenditures under the plan. Proponents of this type of arrangement like the "medicine as private business" aspect. They believe that the plan will succeed or fail based on the physician's quality of care and the response of members, or *the marketplace*, to their care. Proponents also like the fact that only those who are licensed by the medical field are both determining what type of care will be given and are providing the care. This eliminates the criticism that can be leveled against other arrangements if the plan's rules are made and/or reviewed by non-medical personnel or when medical personnel reviewing care given are rewarded monetarily for authorizing as little care as possible. Those who disagree with this type of plan believe physicians should not be business people, and should not have to worry about whether their business is profitable or not. Opponents can include those who believe all health care providers should operate on a not-for-profit basis.

Compensation plans may not fall easily into one of these four groups, but may include a mixture of elements from each basic type. However, the common element found in managed care compensation plans is that they each include methods to control health care costs.

Physician as Gatekeeper

Another way managed care plans reduce expenditures is through the utilization of physicians as gatekeepers. Each member is generally assigned or selects a primary care physician who must refer the patient to specialists and authorize tests and hospitalization. By placing the primary care physician in this position, managed care plans have a method of overseeing what care is being prescribed and to reduce unnecessary procedures. One of the reasons this type of structure was put into place was to combat the complaints of the 70's that doctors were prescribing unnecessary hospitalization and other treatments.

Risk Selection

Managed care plans may also reduce plan expenditures through selection of the members within the plan. State regulations may not allow denial of coverage by a plan for many health reasons, and federal regulations also prohibit group plans from excluding people with certain health conditions, but plans may still practice risk selection in ways other than denying entry into a plan. Marketing devices, such as offering exercise programs, can attract healthier members. Some employer plans include rewards for those who meet certain health lifestyle criteria. Another way plans practice risk selection is to include, within state regulations, rating systems. Under rating systems, members are divided into sub-groups. All members of each sub-group are charged the same premium or fee for membership in the managed care plan. In this way, members of the various sub-groups are charged a fee based on the risk factors they contain.

External Review

Finally, some managed care plans utilize external vendors to perform reviews of care prescribed, member satisfaction and other elements of managed care administration. The use of external vendors is becoming more popular. By using an external vendor, managed care plans hope to reduce the criticism that profit-mongering is the motive behind care prescribed and care denied and hope to be able to demonstrate that they are giving reasonable and adequate care. An external vendor should be able to provide an additional “check” on the tendency of physicians to either over prescribe or under prescribe care. Some regulators are pushing for state-run or state regulated external vendor organizations. Those who believe the state should be involved are wary that for-profit external vendors will act in favor of the managed care plans paying their fees.

Managing health care costs is a difficult endeavor. Plans must balance many factors in their attempts to provide the best care at the lowest prices. The many complicated and interrelated issues involved, and the concerns of regulators, employers and plan members will continue to keep managed care in the center of public debate.

Chapter Three: Managed Care Plan Provisions

Managed care plans contain some unique provisions and terms. This chapter will explain many of the important elements included within them.

Enrollment

The most common method of enrolling in a managed care plan is through an employer. Those eligible for Medicare can also enroll in managed care plans. Some managed care programs make themselves available to individual purchasers as well. For those who may have difficulty joining a managed care program because they are self-employed, are not eligible for employer benefits or don't have access to managed care plans on an individual basis, managed care may be available on a group basis through state or local governmental programs or through cooperatives or associations.

Enrollment Through An Employer

When an employee joins a managed care program through an employer, the employee becomes part of a *group coverage plan*. Group coverage plans provide specified benefits to members who meet the criteria of *the group*. All employees of a business or several businesses may comprise a *group*.

Group coverage plans, when compared to individual coverage plans, generally have certain advantages:

1. They are generally less expensive than individual plans.
2. An individual or family member that may have difficulty receiving medical coverage will generally be accepted under a group coverage plan.
3. The employee portion of the premium payments is often made as a payroll deduction, so the employee will not accidentally cancel coverage through non-payment of premium.

Group plans can have disadvantages as well. In some cases, the lower premium associated with the plan occurs because the provisions within the plan include more limited coverage benefits than individual plans. Or, waiting periods may be included before certain benefits apply under certain group plans. However, regulations applicable to group health plans limit the extent to which a group plan can include waiting periods, as will be discussed later in this chapter. Group plans may also provide limited coverage, such as a lifetime coverage cap. It may be because of limited coverage provisions or coverage caps that the plan does not exclude those with conditions that would prohibit them from being covered by an individual plan.

Group plans do not always include all these disadvantages. They may be relatively less expensive due to the high number of members within the plan resulting in lower costs due to risk spreading. The managed care organization, such as an HMO, may have contracted with providers within the plan to give care at significant discounts.

Employers may offer a choice of managed care plans or traditional health plans to employees. Some may offer more than one type of managed care plan, or may offer both a POS and HMO plan. If managed care is not available in the area in which the business operates, the employer will not be able to offer managed care. This situation is more and more uncommon, since managed care popularity has caused it to spread throughout the country.

An employee may join a managed care plan through an employer when hired. New members can also join during the annual open enrollment period. Once an employee is enrolled, if the employee is responsible for all or a portion of the premium payment, the payment will generally be deducted from his or her paycheck at least monthly, and remitted to the managed care organization.

Enrollment as an Individual

Many managed care organizations offer plans to individuals, such as the self-employed. As more and more people leave corporations to operate as independent contractors or to start their own businesses, more and more managed care organizations are offering plans within the individual marketplace.

Individual plans may require a more lengthy application process than group plans, and may also require a medical examination before a member can be accepted into the plan. Some states have regulations that do not allow a managed care organization to do such health screening. State regulations may also prohibit excluding individuals from coverage due to pre-existing conditions, from adding exclusions to a health plan, or from extending waiting periods based on an individual's pre-existing conditions. Federal regulations regarding pre-existing conditions and waiting periods do not generally apply to individual health plans.

Enrollment Through a Cooperative

The process of enrolling through a cooperative or association is similar to enrolling through an employer in some ways. Coverage through cooperatives and associations, whether governmental, an association of CPAs, of computer programmers, or through a credit union or even membership in a superstore, is all offered on a group basis. A limited application process is used, and no medical exam is generally required. All applicants are generally accepted. Unlike enrolling through an employer plan, a member enrolling through a cooperative or association must pay the entire premium amount. The premium can normally be automatically withdrawn from a bank account on a monthly basis in order to make the process more convenient and reduce the likelihood that a payment will be missed and the coverage cancelled.

Pre-Existing Conditions

A plan's provisions regarding pre-existing conditions can be very important to the purchaser. Many forms of managed care plans do not place any restrictions on pre-existing conditions. HMOs for example, generally do not. However, plans such as POS plans may impose waiting periods for certain conditions if care is received outside of the managed care network. State regulations may prohibit health plans from excluding conditions or imposing waiting periods, however.

Pre-existing condition exclusions and waiting periods are also limited through federal *COBRA* regulations and other related laws. The *Consolidated Omnibus Budget Reconciliation Act of 1985*, or *COBRA*, includes requirements for group health plans regarding health care continuation. *COBRA* has been amended and expanded by the Omnibus Budget Reconciliation Act of 1986 (*OBRA '96*), the Tax Reform Act of 1986 (*TRA '86*), the Technical and Miscellaneous Revenue Act of 1988 (*TAMRA*), the Omnibus Budget Reconciliation Act of 1990 (*OBRA '90*), the Small Business Job Protection Act of 1996 (*SBJPA*) and the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*). Under these regulations a *group health plan* is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. The regulations also apply to certain individual health plans, if maintained by an employer or employee organization for employees.

Under *COBRA*, generally, *qualified beneficiaries* must be given the opportunity to continue health care coverage provided through an employer's health plan. A *qualified beneficiary*, under IRS final regulations issued December 28, 1998, is in general, (1) *any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee, or (2) any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.* *Qualifying events*, or events that trigger *COBRA* continuation coverage, include termination from employment, resignation, death, entitlement to Medicare, reduction in hours to a level below that required by the

employer for health care coverage, employer bankruptcy, and in certain cases divorce, legal marital separation, and a child's loss of eligibility for coverage.

If a health plan covered by COBRA does not comply with requirements under COBRA, an excise tax is imposed on the employer and/or the plan. In addition, qualified beneficiaries who are harmed by this lack of compliance can file a lawsuit against the plan or employer for damages.

The terms of COBRA allow for the qualified beneficiary to be required to pay for the continuation of coverage; the employer does not have to pay the premium. In addition, the plan may charge additional administrative costs of up to 2% of the premium fees. The coverage under COBRA is required to be generally the same as the coverage the qualified beneficiary had before the qualifying event. The employer can give the beneficiary the option of eliminating benefits that are considered *noncore*, such as dental and vision care.

HIPAA regulations, under *Section 9801, Increased portability through limitation on preexisting condition exclusions*, state that, generally, a group health plan may only impose a preexisting condition exclusion if the exclusion relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date and the exclusion is in force for not more than 12 months, or up to 18 months for late enrollees. Under certain conditions the maximum exclusion period may be reduced by periods of *creditable coverage*. For example, if an individual was enrolled in a group health plan upon being hired by an employer, the new group health plan must give the employee credit for the time covered by the original health plan. The regulations define creditable coverage to include coverage under the following:

- A group health plan.
- Health insurance coverage.
- Part A or part B of title XVIII of the Social Security Act.
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- Chapter 55 of Title 10, United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under chapter 89 of title 5, United States Code.
- A public health plan.
- A health benefit plan under section 5(e) of the Peace Corp Acts.

Also under HIPAA, a group health plan may not impose any preexisting condition exclusion to:

- a newborn who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;
- a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage; or
- any condition related to pregnancy.

Certain coverages may carry additional waiting periods, however. These coverages include:

- Prescription coverage
- Vision coverage
- Dental coverage
- Mental health coverage
- Substance abuse coverage

However, if the individual had coverage under creditable coverage for any of these items, no additional waiting period can be applied.

Enrollment Eligibility

HIPAA also includes regulations regarding eligibility requirements for group health plans. Generally, a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following factors applicable to the individual or dependent of the individual:

- Health status
- Medical condition (including both physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

However, the regulations found in IRC Section 9802 are not to be construed to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment or service) other than those provided under the terms of the plan, nor to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for *similarly situated* individuals enrolled in the plan or coverage.

Premium Payments

HIPAA also does not allow group health plans to discriminate on the basis of the factors listed previously (health status, medical condition, etc.) in determining premium payments. A group health plan may not require any individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on these factors. These regulations state that they are not intended to restrict the amount that an employer may be charged for coverage under a group health plan or to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Role of the Primary Care Physician

An important issue within a managed care plan is the role of the primary care physician. This physician has a tremendous impact on the type of care the member receives, not just from that physician, but also from other medical caregivers. Under managed care plans, the primary care physician has four important roles: caregiver, consultant, gatekeeper and advocate.

Caregiver

As the name *primary care physician* suggests, under managed care plans, this physician is likely to provide the member with most of the medical care the member requires. Because of the primary care physician's important role, members should select their physician with care.

Managed care plans may differ in the way they decide whom to include as a primary care physician within their plan. Some managed care plans may have several standards a prospective primary care physician must meet in order to become part of the plan. For example, the plan may require the physician to attend certain instructional meetings regarding the plan provisions, may require that the physician have certain educational credentials, may require that physicians provide references from inside the medical community, or may have other screening devices in place to make sure physicians with unsatisfactory practices are not included in the plan.

Once a physician is part of the network, plans may have methods of monitoring the care given and prescribed by the doctor. Some periodically contact members and conduct surveys about the care the member has received. Others have advisory boards that review the care and treatment provided

by primary care physicians within the plan. Many plans also have methods of disciplining or correcting physicians who do not meet the plan's standard of care.

Some plans do not have, or have only minimal, processes in place for the screening of prospective primary care physicians. Others do not have processes to oversee physician's care. Plans without these processes are becoming more and more rare due to the scrutiny managed care is receiving by both regulators and the media. If a member believes a physician is not providing care as required by the plan, and the plan is unresponsive to the member's concerns, the member may report problems to the state's insurance department. Depending upon the type of complaint, the authorized staff of the insurance department often takes steps to see the complaint resolved.

Consultant

The primary care physician also acts as a consultant. If coordinated care is provided, the primary care physician is an important member of the team, helping to decide what type of and to what extent care is provided. The primary care physician also acts as an expert consultant to the member. The member expects this physician to know when to refer the member to specialists or when to undergo special tests.

Gatekeeper

The primary care physician also acts as a gatekeeper under many managed care programs. The primary care physician must provide referrals in order for the member to see a specialist, to undergo certain tests, or be provided with hospitalization or surgical care.

Advocate

Finally, the primary care physician is an advocate for the patient. The primary care physician works with the managed care organization to ensure that the member receives the care needed. Sometimes, the physician must prove to the managed care organization that the patient requires care that the managed care organization does not normally provide. The physician may have to take up the patient's cause with an oversight committee from the managed care organization and provide good, solid reasons why the patient needs special care.

Sometimes, the roles of the primary care physician can be in conflict with one another. As gatekeeper, the primary care physician is responsible to the managed care organization to try to keep care costs down and to prevent the member from receiving unnecessary care. As caregiver, however, the physician must try to provide the best care possible. It is possible that a physician may err on the side of cost control and not refer a member to a specialist when the member needs it. Members of managed care plans should contact the managed care organization if the member believes the physician is not treating him or her as needed. Most managed care plans have a process under which a member can appeal a decision. Some managed care patients have gone to physicians outside the plan to get a second opinion, and if that opinion disagrees with the primary care physician's or the plan's opinion, the member uses the second opinion to encourage the physician or plan to change its mind about what medical care should be given.

Medically Necessary Services

Managed care plans promise to provide *medically necessary* services, within the scope of the plan's provisions. Generally, managed care plans determine what care is medically necessary through a process of *utilization management* or *utilization review*. Whether care is medically necessary or not is based on the managed care plan's utilization review; it is not based solely on the opinion of the patient's physician.

Basically, under a utilization review process, the managed care organization compiles criteria, or uses criteria experts have compiled, under which various medical treatments will be covered. If a patient's situation meets the criteria, the care received is covered by the plan, and if not, the care is not covered, or only partially covered.

If a member believes that care should be given and covered even though the managed care organization denies the coverage of the claim, the member must file an appeal. The process of the appeal varies based on state regulations and plan rules, but generally, the appeal process is first handled by non-physician medical providers and the appeal then moves up the chain to licensed physicians. Many states now require that physicians sign any care denials and may also require that an explanation of the denial be given to the patient.

Care Provided

Managed care plans provide various types of care. Each type of care provided under the plan may have different stipulations concerning when the care is covered and when it is not.

Preventative Care

Managed care plans generally cover a wide variety of preventative care. Immunizations, screening tests such as mammograms and those for prostate cancer, cholesterol levels and blood pressure, pap smears, as well as care used to manage chronic conditions such as diabetes or asthma, are generally covered.

Plans vary regarding how often tests are covered, for what age groups they are covered, and other criteria that might have to be met in order for various preventative care treatments to be covered. For example, mammograms are often covered on an annual basis once a female reaches forty. Immunizations may be covered only through a child's age twelve. Testing for prostate cancer may be covered for males over fifty. Plans may also vary regarding what type of health care provider can perform exams or tests and whether a referral from a primary care physician is required in order to undergo a test or exam.

Other ways managed care plans may cover preventative care is through the holding of classes or seminars that provide instruction in weight management, smoking prevention, stress management, and management of conditions such as diabetes, high blood pressure or asthma.

Emergency Care

Managed care plans generally divide emergency care into two classifications: *urgent* and *life-threatening*. *Urgent* refers to conditions that need immediate attention, but are not life-threatening. Such conditions may include a broken ankle or broken arm, a severe cut that requires stitches, an extremely high fever perhaps accompanied by a sore throat, or continuous vomiting. Often, a managed care organization will cover such care only if the member contacts their primary care physician of the managed care organization prior to going to the emergency room. Under some managed care plans, such care is only covered if a certain hospital's or hospital network's emergency services are utilized.

Life-threatening refers to conditions that could result in death, serious disability, disfigurement, or a long-term medical problem. Managed care plans do not require authorization from a primary care physician in order for emergency care for life-threatening conditions to be covered. However, many managed care plans require that they be notified within 24 – 48 hours of the member's treatment.

Each plan may have slightly different parameters regarding what conditions must be present in order for care to be covered as a life-threatening emergency. It is common for plans to include the following conditions as those considered life-threatening: possible poisoning, possible heart attack, possible stroke, convulsions, severe burns, loss of consciousness after a blow to the head, injuries as a result of being crushed, and so on.

It can be difficult for a member facing an emergency to be able to distinguish between what conditions are urgent and what conditions are life-threatening. Plans generally recommend calling the primary care physician or the plan before going to the emergency room, if at all possible. If for some reason the member, or the person calling on the member's behalf, cannot reach the appropriate physician or

the managed care organization, he or she should note the time and phone number called so that documentation can be provided to the managed care organization that the member tried to receive instruction and authorization prior to going to the emergency room, if such documentation becomes necessary. The caller should also leave a message at the number called giving the time, a brief description of the condition, and what emergency room will be used.

Managed care organizations today generally cover emergency care based on the *diagnosis* after emergency care is administered. One can imagine that patients may feel unfairly treated by the managed care organization when they believe they need emergency care and the managed care organization does not cover the care given because it turns out the patient's condition did not warrant emergency services. This issue is one being carefully looked at by lawmakers today.

Away-From Home Care

Managed care plans also have differences regarding how they cover care received out of the area in which the member resides and out of the service area the managed care organization. Generally, emergency care is treated by managed care plans in the same manner whether the care is provided within the network or out of the area. Rules regarding away-from home hospitalization or non-emergency care can vary greatly from plan to plan.

Routine care is unlikely to be covered by the managed care plan if performed out-of-the-area. However, some plans cover such care for college students away from home and covered by the plan. Care for conditions such as the flu or serious cold may also be covered if a member calls the managed care organization prior to treatment.

Care From Specialists

Managed care plans also vary regarding the methods under which care from specialists is covered. Some plans require a referral from the primary care physician in order for the plan to cover care from a specialist. Other plans allow the member to go to specialists without a referral, but may not cover all the costs of such care.

Managed care plans may include specialists within the plan network, or the plan may refer patients to specialists outside the plan. Plans may also vary regarding what type of physician is considered a specialist. Specialties that may be covered by the plan include:

- Allergies
- Cardiology
- Ear, Nose and Throat
- Fertility
- Gastroenterology
- Gynecology
- Infectious Diseases
- Neurology
- Obstetrics
- Occupational Therapy
- Optometry
- Physical Therapy
- Radiology
- Speech Therapy
- Surgery
- Urology

Hospital Care

Under managed care plans, hospital care must generally be authorized by the managed care organization and/or the primary physician. The plan may require that the member attend a specific hospital, or may have a choice of hospitals from which the member may receive care.

Under some managed care plans, hospitalization is subject to a utilization review. This review may include both whether hospitalization is necessary and a determination of how long the patient should remain in the hospital. Under other plans, the hospital medical staff will coordinate care with the primary care physician and this team will determine when a patient should be discharged.

Plans can differ regarding which hospitalization services are covered and which are not. For example, private rooms may not be covered, or covered only under certain circumstances. Television provided in the room and other non-medical services may or may not be covered by the plan.

Skilled Nursing and Rehabilitative Care

Skilled nursing and rehabilitative care can be given at home or at a skilled nursing facility. Managed care plans may cover skilled nursing and rehabilitative care. The plan may require that such care be authorized by the plan prior to being given in order for the care to be covered. The plan may have health care providers within the plan that will give the skilled nursing or rehabilitative care, or may allow the patient to receive such care from providers outside of the plan. Skilled nursing and rehabilitative care covered by managed care plans is short-term care, and generally will be covered for a maximum of a specified number of days. Long-term care, such as that provided by nursing homes to elderly patients, is not generally covered by managed care plans.

Home Health Care

Health care services are now more and more often provided in the home. Types of services that may be given in the home include nursing services, home health aide services such as bathing and dressing, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical services, social services, and medical supplies or equipment services provided in the home. Managed care plans may cover this care if authorized by a primary care physician. Home care such as meals and housekeeping are not generally covered by managed care plans.

Hospice Care

A hospice is a facility that primarily provides care for terminally ill patients. Hospices do not provide care to treat the illness or disease, such as chemotherapy. Rather, a hospice provides pain medication and other services such as counseling to help the terminally ill patient be as comfortable as possible. Managed care plans may cover such care. Plans that cover hospice care generally require that the care must be authorized by the patient's primary care physician. Like skilled care, hospice care is generally covered for up to a maximum number of days.

Alternative Medicine

It is becoming more common for managed care plans to cover alternative medical treatments such as acupuncture, chiropractic care, homeopathic care and nutritional therapy. However, many plans still do not. Managed care plans generally cover treatments that are acceptable to the medical community at large. Formularies and utilization review processes use well recognized treatments and remedies. Most alternative medical treatments do not meet such criteria.

Family Planning

Family planning services, such as providing treatment to combat infertility, pregnancy testing, birth control counseling and so on, may be covered under managed care plans. Some plans may provide coverage for all family planning services, and other plans may not. State laws may require that certain items be covered by managed care plans, such as birth control pills if a patient is covered by a prescription drug plan.

Plans that cover family planning services such as infertility treatments vary in which services are covered and which are not. Infertility treatment may be covered only up to a certain age, for example. The plan may only cover treatment for up to a specified period of time, or for a certain number of treatments.

Maternity Care

Because managed care plans focus on preventative care, they provide coverage for prenatal and maternity care. Generally, managed care plans cover all checkups during pregnancy, necessary tests and child birthing, breast-feeding and newborn care classes. The plan will also cover care needed during labor and delivery. Once the baby is born, managed care plans cover immunizations and well-baby checkups. Some plans also provide follow-up care and instructions once the mother and baby are at home soon after giving birth.

Some plans will allow the mother to continue to receive care from a previous physician if the mother becomes a member while she is pregnant. Others require that the mother choose a physician within the plan's network. Some plans will cover the use of a midwife.

Pediatric Care

As mentioned, managed care plans cover immunizations for children. They also cover visits to the physician for treatment for earaches, colds, sore throats, the flu, diarrhea, scrapes and bruises and other common childhood ailments. As children get older, many plans offer services such as classes or counseling on drug prevention, smoking prevention and other issues affecting teenagers today.

Senior Health care

Managed care plans include many benefits for people as they age. Many cover annual checkups for people in or past their middle years for items such as:

- Breast cancer
- Prostate cancer
- Colorectal cancer
- Blood pressure levels
- Cholesterol levels

Care for conditions commonly associated with aging is also covered by many plans. Care can be received for diabetes, osteoporosis, arthritis, hearing loss, strokes, incontinence, digestive problems, Alzheimer's disease, and other conditions, whether easily treatable or serious. Some plans also cover care given to treat mental health conditions such as depression and anxiety. Classes and seminars may also be provided through the plan which cover topics of interest to patients in or entering their senior years.

The need for prescription drugs often increases with age and prescription coverage is offered by managed care plans, although the coverage may require payment of additional premium. Many plans include provisions enabling the review of the prescriptions prescribed by physicians within the network to ensure safety in the prescriptions' use.

Primary care physicians can often meet the care needs of aging patients, but those with certain conditions may need to see specialists or select a new primary care physician with experience in geriatrics or other relevant area. It is also important to remember that managed care plans do not provide long-term care benefits. Long-term care insurance policies may be an additional form of insurance that aging adults require to meet health care needs.

Women's Health

Women have special health care needs. Women may require care related to menstruation, fertility, reproduction, childbirth, menopause, breast cancer, cervical cancer and other conditions related to

their gender. Some managed care plans include women's health clinics as part of their network of providers. Some also allow a gynecologist to be a primary care physician.

Mental Health and Substance Abuse Care

Managed care plans vary in the scope and depth of coverage for mental health and substance abuse related care. Some state laws include regulations that require that certain minimum levels of such care be covered. Other states have no such requirements.

Some plans may cover such care for a certain number of visits. For example, a plan may cover up to three visits to a psychologist for marital counseling, or may cover drug abuse therapy up to a certain maximum dollar amount of services. A plan may also cover only assessment services.

Plans may allow a member to self-refer to a mental health or substance abuse emergency center. Others allow self-referrals for non-emergency mental health care, especially if mental health care providers are a part of the plan's network. Some require a referral from a primary care physician for such services.

Plans that provide coverage for substance abuse and mental health care differ regarding whether the patient may select their own therapist, whether a therapist will be selected by the plan, or whether care is covered if provided by a therapist outside the plan network.

Some plans may offer group counseling or programs for conditions such as eating disorders or coping with abuse, or other mental health conditions that can be improved by such programs. Other plans do not offer group counseling for these conditions.

Prescription Drugs

Prescription drug coverage is generally offered by managed care plans for additional premiums or member fees. Some plans cover prescriptions filled by network pharmacies only and others have no restrictions regarding where prescriptions must be filled in order to be covered. Of course, prescriptions are generally covered only if written by a primary care physician or other authorized physician under the plan.

It is not uncommon for managed care plans to cover prescriptions based on a *formulary*. A formulary is a list of medications that are used to treat various conditions and is used by physicians within a plan as a guide for prescribing medication appropriate to a patient's condition. Generally, if medications are prescribed according to the formulary, the managed care plan will cover these medications at a higher level than medications not on the list.

As with other services covered, managed care plans cover prescription drugs considered medically necessary. Experimental drugs and drugs used for cosmetic purposes are not covered. Drugs used for birth control purposes may or may not be covered; state regulations may require that they be covered.

Prescription drug coverage often has associated with it a separate premium or different copayment amount than other care covered under a plan. Drugs may be covered on a percentage of cost basis rather than on a copayment basis. Prescription drugs may also be subject to a specified annual coverage limit separate from other coverage limits.

Other Provided Care

Other care that may be covered under managed care plans can include dental, hearing and vision care. Plans may categorize this care as *medically necessary*, *preventative* and *not-medically necessary*.

Medically necessary care includes care such as that required after an accident, or care required due to an infection. Preventative care includes care such as teeth cleaning or routine hearing and vision examinations. Non-medically necessary care includes items such as dentures, hearing aids and corrective lenses.

Some managed care plans offer no coverage or limited coverage for preventative vision, dental or hearing care. Coverage for routine dental examinations may be limited to patients under the age of 12. It is not uncommon for preventative vision care not to be covered under low-fee managed care plans.

Administration of Managed Care Plans

Another important aspect of managed care plans is their administration. The way a plan is administered can affect the patient's benefits over time. Administration of the plan includes implementation of coverage changes, changes in premium, how coordination of benefits is handled, how coverage is terminated and the process involved when switching coverage plans.

Coverage Changes

Coverage or benefit changes can occur for a number of reasons under a managed care plan. State or federal regulations may result in required changes in benefits, the employer who sponsors a plan may negotiate for changes in coverage with the managed care provider, or the managed care provider may change product specifications. Technological advances and new medically accepted treatments can motivate a managed care plan's decision makers to change the scope of benefits provided.

Before a coverage change takes effect, the plan will notify each member. The plan will issue an amendment to the policy or may issue a new contract with updated provisions.

Changes in coverage cannot be made if state or federal regulations prohibit them. If a regulation exists requiring certain minimum levels of coverage or that disallows certain exclusions, changes that would cause these provisions to violate regulations cannot be made. Allowable changes generally include such items as:

- Increases in copayments or member fees
- Changes in various limits of coverage, for example, changes in charges for prescription coverage
- Broadened coverage based on state or federal requirements
- Changes in the physicians, clinics or other health care providers within the plan's network
- Changes due to mergers and acquisitions in the managed care field

Premium or Fee Changes

Premiums can generally change annually. Under a group plan, all affected members will experience the premium change at the same time, such as at the beginning of a new plan year. Under individual plans, premium changes will generally be made at each policy anniversary.

Premiums may be changed for many reasons. Under group plans, the contract with an employer will reflect expected expenses related to the group insured. Some groups have relatively higher expenses than another group for various reasons. A group of employees may have a high number of older employees that begin to need additional care. Or, a business may include several females in their child bearing years and a relatively high percentage of them become pregnant. Children within the families enrolled may happen to have a high incidence of allergies, asthma, or other serious condition. If a group happens to incur relatively higher expenses than the managed care plan expected, premiums will likely go up.

The age of enrollees also affects the premiums charged. A new premium bracket may apply at age 30, 40, 50 and so on. When a member enters the new premium bracket, premiums go up.

The managed care plan must notify members within a specified time prior to the date the fee change takes effect. Depending on plan rules and, often, state regulations, notification may be anywhere from thirty to ninety days before the new fee schedule's implementations.

Coordination of Benefits

Some people are covered by more than one managed care or insurance plan. For example, both spouses may be employed and each enroll the other in their employer-sponsored health plan. Other circumstances that can result in being covered by more than one plan can include being involved in an auto accident and the applicable auto insurance providing certain medical expense coverage, being involved in an accident at another person's home and applicable homeowner's insurance providing medical coverage, or being involved in an accident at work where Workers' Compensation insurance applies.

Managed care plan language varies regarding how its coverage is applied when there is duplicate coverage. Generally, all insurance policies and managed care plans exclude coverage if care is covered by Workers' Compensation, government provided disability insurance and the like. If more than one insurance policy does apply to the same injury, accident, sickness or other condition, it is common for the language in a policy such as a homeowners or automobile policy to assume that the other insurance is the *primary* insurance. If both plans or contracts assume that the other is the primary insurer, the terms of the plan will often allow for a sharing of the cost of care, up to the applicable limits of coverage. Managed care plan provisions can be complicated. Under some circumstances, a plan may be primary, and if other circumstances apply, the same plan may be considered to provide secondary coverage.

Subrogation

An important legal concept applied to many types of insurance and to managed care plans is the concept of *subrogation*. To subrogate means essentially to substitute. As this concept relates to insurance or health care coverage, it means that the insurer's or health care plan's right to collect payment from a liable party is substituted for the patient's right if the insurer or health care plan has paid for the patient's care. For example, if someone causes a patient's injury and the managed care plan pays for the patient's care, the managed care plan can "go after" the person responsible for causing the injury in order to be recompensed for the payments made to cover the patient's cost of care. It is also possible that the managed care plan will "go after" the patient for compensation. This can occur if the patient receives payment for the injury from another insurer or from a responsible party, and the managed care plan had paid for the care associated with the injury. The managed care plan will expect to be reimbursed for the expenses it has incurred on the patient's behalf.

Terminating Coverage

The provisions under which coverage may be terminated vary based on the plan, state regulations and whether the plan is a group or individual plan. Under employer-sponsored group plans, a member's coverage may be terminated, subject to COBRA rules, if the employee resigns, is terminated, or retires. Termination can also occur if the employer does not pay the applicable premium. Another reason coverage may be terminated under either employer sponsored or individual managed care plans is if the plan has rules that require that members live within a specified area and the member moves. Coverage can also be terminated if it is found that the member or applicant has provided false or misleading information on the plan application, or if a member commits fraud. Finally, most plans terminate members once they are eligible for Medicare, or require that they switch to a Medicare approved program offered by the plan.

A managed care plan must follow certain rules when termination occurs. State regulations require that adequate notice be provided prior to termination and many also require that reasons for the termination be given and the options the member has to avoid termination be stated. Of course, if fraud were committed, the member cannot avoid termination.

As discussed earlier in this chapter, if a managed care member is terminated under an employer-sponsored plan, the plan must follow COBRA rules, and so may be able to continue coverage by paying the required premium. Besides the option of continuing coverage through COBRA, some managed care plans offer group plan members the ability to convert to individual coverage. The plan may have a variety of individual plans from which to choose and the former group member may be able to join one that meets his or her coverage needs, perhaps with a higher deductible than the group plan, so that the coverage is affordable.

Switching Coverage Plans

As discussed earlier under the topic *Preexisting Conditions*, in certain cases, a group health plan must give a new member credit for prior coverage, which reduces the length of the waiting period related to certain preexisting conditions. The prior health plan must provide certification of creditable coverage at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, or in the case of an individual become covered under COBRA, at the time the individual ceases to be covered under COBRA. A plan must also provide documentation of creditable coverage upon the request of an individual made not later than twenty-four months after the date of cessation of coverage.

Also, as mentioned, under state and federal COBRA rules, qualified beneficiaries must be given the opportunity to continue health care coverage provided through an employer's health plan.

Managed Care Plan Contracts and Agreements

Managed care plan contracts and agreements generally include the following components:

- Declarations Page
- Copy of Enrollment Application
- Summary of Benefits
- Definition of Terms
- Premium Payment Provisions
- General Provisions
- Waiting Period Provisions
- Medically Necessary Care Provisions
- Prior Authorization Provisions
- Exclusions
- Terms and Conditions
- Covered Expenses
- Additional Benefits and Limitations
- Disclosures
- Endorsements

Declarations Page

The Declarations Page of the contract generally includes the name of the insurer or managed care organization issuing the contract, the name of the plan, the name of the policyholder or member, the policy or member number and the effective date of the agreement. It also includes whether the member is covered by any optional benefits, such as prescription drug benefits.

Definition of Terms

Managed care contracts include the definitions of important terms used within the document. The definition of the term can serve to limit the boundaries of coverage as they relate to the item defined. For example, if a managed care plan provides coverage for Chiropractic Care and includes this definition:

Chiropractic Benefits - means the following benefits when performed by a Chiropractor as defined below: initial evaluation visit, subsequent chiropractic manipulation, and associated physical medicine and related lab and x-ray.

Based on this definition, the plan member can expect coverage for any care that falls within the scope of the definition, and which are not modified or excluded through any of the other provisions in the agreement.

Terms that are likely to be defined in the contract include the following:

- Benefits
- Case
- Certificate of Health Coverage
- Coinsurance
- Conditions
- Copayments
- Cosmetic Surgery
- Creditable Coverage
- Custodial Care
- Deductible
- Disability
- Disease
- Effective Date
- Eligible Dependent
- Emergency / Urgent Care
- Endorsement
- Experimental Procedures
- Future Eligible Dependents
- Guaranteed Renewable
- Grievance
- Home Health Care
- Hospice Care
- Hospital
- Hospital Inpatient
- Hospital Outpatient
- Illness or Infirmary
- Industrial Inquiries or Occupational Disease
- Inquiry
- Maternity Benefits
- Medical Emergencies
- Medically Necessary Care
- Medicare
- Medicare Benefits
- Member
- Nurses
- Physical Therapy
- Physicians' Services
- Preferred and Non-Preferred Provider
- Pre-Existing Conditions
- Prescription Drugs
- Prior Authorization
- Proof of Death
- Service Area

- Skilled Nursing Facility
- Surgery
- Workers Compensation

Premium Payment Provisions

The premium payment provisions describe generally how the premium payment amount is applied. For example, if the plan charges different rates based on whether the coverage is for an individual, an individual and spouse, an individual and children, or a family, the premium rate differences will be described. The methods members may use to pay premiums are also explained, such as the use of bank drafts, payroll deduction or direct payment to the managed care insurer or organization. Grace period conditions, which may be state regulated, may also be explained within these provisions.

General Provisions

General provisions govern the major administrative and benefit rules of plans. The general provisions found in managed care plans may include the following:

- **Changes.** Generally, no changes may be made to a managed care agreement unless they are approved in writing by the managed care organization and are endorsed or attached to the agreement. Some states require that a notification of disclosure be provided to the member that specifies the steps that will be taken before any changes are made.
- **Locations Physician Services May Be Provided.** The locations physician's services may be given are generally limited to the physician's offices, a hospital as defined in the contract, and in some cases, the member's home and at the location of an emergency.
- **Physicians and Hospitals Outside Of the Plan or Network.** This type of provision will explain the rules regarding what type of coverage applies if a member uses physicians or hospitals outside of the plan or network. Such provisions will also state under what conditions the coverage applies when outside of network care is provided.
- **Right to Examine Records.** The member generally gives the right to the managed care organization and its providers to examine medical records. Many states today require that the managed care organization provide a disclosure to members explaining in detail for what purposes the organization will use information, what information the organization will not release without prior patient consent, and the rights the member has to approve, limit, deny access or release personal health information.
- **Reinstatement.** Reinstatement provisions are often governed by state regulations. Reinstatement and grace period provisions apply when premium payments are missed or late. Depending upon how late the premium payment is, the managed care organization may reinstate the member without a new application, or may require a new application in order for the member to be reinstated. These provisions also specify that certain conditions, such as those due to accidental injury, are not covered if they occur before the reinstatement date.
- **Claims.** Claims provisions cover claim submission requirements, including to whom claim forms must be submitted and within what time frame. The time frame of claim payments will also be addressed. Response times to claims are often state regulated.
- **Claim Appeals.** An important part of managed care contracts are the appeals process provisions. These provisions include the specific requirements of the appeal process, such as how the appeal must be made, such as in writing, the time-frame in which the appeal must be filed with the managed care organization, the time-frame under which the appeal will be reviewed, and in what form the member will receive a response.
- **Grievances and Complaints.** Provisions regarding grievances and complaints generally include the address and phone number to which grievances or complaints should be made, what type of response the member should expect, e.g. a written response, and other information regarding the grievance and complaint process. The member's general *rights to complain* may also be enumerated.

- **Right to Perform Physical Exams and Autopsies.** The managed care organization may exercise the right to perform physical examinations as often as reasonably required in the processing and settlement of claims. The managed care organization may also have the right to perform autopsies, if the law allows.
- **Misstatement of Age.** If a member's age is misstated, generally benefits under a managed care plan will be paid based on the benefit amounts the premium paid would have purchased at the member's correct age.
- **Duplication of Benefits.** Duplication of benefits provisions are relevant if other coverage applies to a member. If other coverage does apply, the benefits from the managed care organization may be reduced.
- **Subrogation Provisions.** Subrogation provisions discuss when the managed care organization has the right to recover benefits paid on the member's behalf.
- **Cancellation Provisions / Guaranteed Renewable Contracts.** Cancellation provisions are also generally governed by state regulations. Cancellation provisions include the terms under which the managed care organization can cancel or not renew the contract. Many states require health coverage plans to be guaranteed renewable. If the policy is guaranteed renewable, the managed care organization has very few allowable reasons for canceling a contract with a member. Under guaranteed renewable contracts, reasons a managed care plan can cancel a policy or agreement include lack of premium payment, fraud or misrepresentation on the part of the member, or when the managed care organization stops offering contracts to anyone.
- **Dependent Eligibility Provisions.** Dependent eligibility provisions include information regarding when eligibility ceases for adult children and if a member and spouse become divorced. Some states require that the ineligible dependent be allowed to convert their coverage to a new contract with the managed care organization.
- **Limits of Liability.** Depending on the terms of the contract, it may include statements to limit the liability of the insurer or managed care organization. Many plans state that the physician or hospital giving care to the member is responsible for the care the member receives.

Waiting Period Provisions

Waiting period provisions, as is true with all provisions in a plan, must conform to state and federal regulations. As discussed, COBRA and related regulations impact the scope and extent of the waiting periods that can be included in most managed care plans.

Medically Necessary Care Provisions

Managed care agreements include provisions that explain that coverage is based on what is medically necessary. Medically necessary care does not always include all the care a physician may suggest or prescribe.

Prior Authorization Provisions

The prior authorization provisions of the contract will explain what type of care must be authorized prior to its receipt in order for it to be covered. Types of care that are commonly subject to prior authorization can include:

- Elective surgery
- Inpatient hospital admissions
- Outpatient surgical procedures
- Skilled nursing facility admission, Home Health services or Hospice admission
- Rehabilitative care
- Chemical dependency, mental, or nervous conditions admission
- Obstetrical patients in their first trimester
- Diagnostic and screening procedures
- Services from a physician outside the plan's network
- Organ transplantation

Emergency and Urgent Care Provisions

Emergency and urgent care are subject to different prior authorization rules than are other procedures. Plans may require that they be notified within a specified period, such as 48 hours, after certain emergency treatment is sought. Types of emergency or urgent care that the plan must be notified about may include:



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- Hospital admission
- Admission to skilled nursing facilities, home health services or hospice
- Admission to rehabilitation
- Chemical dependency, mental and nervous conditions admission
- Inpatient, outpatient and short stay cardiac catheterization procedures
- Durable medical equipment
- Diagnostic and screening procedures in excess of certain dollar amounts
- Outpatient surgical procedures
- Services from a physician outside of the plan's network

Utilization Review Provisions

Utilization review provisions explain the utilization review process used by the managed care organization. Today, the member may be able to request the criteria used to review and make the medical necessity determination for a particular condition or procedure from the managed care organization.

General Exclusions

The types of care that the plan does not cover are included in the general exclusions section of the agreement or contract. Depending on the plan, exclusions may include:

- Acupuncture
- Admission prior to coverage
- Alcoholism and related conditions
- Chemical dependency and related conditions
- Cosmetic or reconstructive surgery
- Custodial care
- Dental procedures
- Experimental procedures
- Hearing aids
- Infertility
- Lifestyle modification
- On-the-job injuries covered by Workers' Compensation
- Orthotic devices
- Outpatient treatment for mental or nervous disorders
- Services through city, county, state or federal law
- Sexual disorders
- Sterilization and related conditions
- Vision services
- War-related conditions

Benefit Terms and Conditions

The terms and conditions provisions of an agreement include the maximum benefit the policy will pay, any deductible terms, and the way the plan limits apply when more than one family member is covered.

Covered Benefits

The covered benefits provisions outline the benefits under the plan. Generally, benefits of managed care plans include preventative care benefits, women's health benefits, physician services such as home and office visits, surgery, and visits in the hospital, hospital and other facility services and optional prescription drug benefits.

Additional Benefits

Additional benefits may be provided under managed care plans. These may include accident coverage, certain oral surgery, ambulance services, certain appliances and supplies, certain Home Health and Hospice services, outpatient rehabilitation or physical therapy, transplants, mental or nervous disorders, maternity benefits, case management, and accidental death benefits.

Disclosures

Disclosures may also be included in a managed care plan. States may require disclosures pertaining to confidentiality of information, plan changes, emergency care services, the utilization review procedure and the grievance process, among others. Disclosures provide more in-depth information about the provisions and processes the plan has in place. States generally require disclosures about items the state believes are critical to the member's fair treatment from the plan.

Endorsements

Endorsements may be added to contracts because of optional benefits selected by the member, or because regulations cause the general provisions of the contract to be amended. For example, if certain states require a policy to be guaranteed renewable, an endorsement regarding the guaranteed renewable provisions will be included in policies issued in those states. Endorsements may cover cancellation or termination policies regulated by the state, or may add certain coverages the state requires to be included in all health coverage plans issued to its citizens.

Medical Savings Accounts

The Medical Savings Account, or MSA, was created by the Health Insurance Portability and Accountability Act of 1996. This Act authorizes an MSA pilot program. The program allows 750,000 MSAs to be established between 1997 and the year 2000. After this time period, Congress must act in order to allow for the establishment of additional MSAs.

The MSA was created as a means to reduce health care expenses. Under an MSA program, the individual pays for health care directly. This is in contrast to coverage through a conventional health coverage plan, where the insurer or managed care organization decides which medical expenses to pay for, and how much to pay. By giving the individual the freedom to pay for just those services the individual needs, health expenses should decrease, Congress reasoned. In addition, the individual has an incentive to keep health costs low, since unused values of the MSA can be used for future health care expenses. While money remains in the MSA, it grows tax-deferred. Contributions to MSAs may be deductible as well. MSA accounts can be used in conjunction with high deductible managed care plans.

An MSA is basically a personal savings account used to pay for unreimbursed medical expenses. A high deductible health plan is purchased on the MSA holder. The MSA holder contributes an amount not greater than a certain percentage of the deductible into the MSA. The amount contributed earns interest tax-deferred in the MSA. When the MSA values are distributed to pay for certain medical expenses, the amount distributed is tax-free. Other distributions are taxable.

Eligibility and Contribution Rules of MSAs

Eligibility

MSAs are available to employees or the spouse of an employee of a “small employer” who maintains an individual or family “high-deductible health plan” for the employee. MSAs are also available to self-employed individuals and the spouse of self-employed individuals who maintain an individual or family “high-deductible health plan” covering the individual and or spouse.

The term “small employer” is defined in IRC section 220(c)(4):

(4) Small employer.

- (A) *In general. The term “small employer” means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.*
- (B) *Employers not in existence in the preceding year. In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.*
- (C) *Certain growing employers retain treatment as small employer. The term “small employer” includes, with respect to any calendar year, any employer if—*
 - (i) *such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,*
 - (ii) *any amount was contributed to the medical savings account of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and*
 - (iii) *such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.*

High Deductible Health Plans

A high-deductible health plan is defined in IRC section 220(c)(2):

(2) High deductible health plan.

- (A) *In general. The term “high deductible health plan” means a health plan –*
 - (i) *in the case of self-only coverage, which has an annual deductible which is not less than \$1,500 and not more than \$2,250.*
 - (ii) *in the case of family coverage, which has an annual deductible which is not less than \$3,000 and not more than \$4,500, and*
 - (iii) *the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—*
 - (I) *\$3,000 for self-only coverage, and*
 - (II) *\$5,500 for family coverage.*

The deductibility levels and out-of-pocket expense levels in code section 220 are indexed for inflation beginning after 1998. There is no requirement that the high-deductible insurance plan be offered by any specific type of health coverage provider.

If an employee is also covered by a health plan that is not a high-deductible health plan, the employee is not eligible for an MSA. However, an employee may maintain certain types of insurance that will not be considered when determining whether the employee is covered by a non-high-

deductible health plan. Insurance that covers accidents, disability, dental care, vision care or long-term care does not cause ineligibility for an MSA. Neither does Medicare supplemental insurance, insurance if substantially all the coverage relates to liabilities under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, insurance for a specified disease or illness, or insurance which pays a fixed amount per period for hospitalization.

Contributions

Contributions to MSAs may be made by the eligible employee or spouse, or by the employer. If an employer makes a contribution to the MSA, the employee or spouse may not make a contribution to the MSA for that tax year. If a self-employed individual or spouse of a self-employed individual establishes an MSA, the self-employed person or spouse makes the contributions.

Maximum Contributions

The maximum monthly contributions which may be made to an MSA are 65% of the deductible of an individual coverage high-deductible insurance plan and 75% of the deductible of a *family coverage* high-deductible insurance plan, based on each month the individual is eligible for coverage. A family coverage plan is one that is not an individual coverage plan.

Assume an individual is covered by an individual coverage high-deductible plan which has a deductible of \$1500. He became eligible for an MSA on April 1, and remained eligible through December 31 of that year, or for nine months. His maximum contribution to an MSA would be $((65\% \times 1500) \times 9 \text{ months}/12 \text{ months})$, or \$731.25. If he had been eligible for the full calendar year, his maximum contribution amount would have been \$975.

Deductibility of Contributions

Contributions are deductible in the tax year they are made. If the employer contributes to the MSA for an employee, the employer excludes the contribution amount from the employee's income. If the eligible employee or the self-employed individual makes the contribution, the employee or self-employed person takes a deduction against adjusted gross income for the contribution to the MSA. The amount deducted or excluded from gross income cannot exceed the maximum contribution limit of MSAs.

Spousal Rules

If an individual coverage health plan is owned, MSA spousal rules do not apply. However, if either spouse has a family coverage plan, to determine the applicability of MSA contribution and eligibility rules, the following rules apply:

- Both spouses are treated as having family coverage. Therefore, the maximum contribution level for the spousal MSAs is 75% of the deductible amount of the family coverage insurance.
- Unless the spouses agree to a different division, the contribution maximum for each spouse's MSA is equal to 50% of the total maximum contribution level.

Like IRAs, each MSA is individually owned. The contributions and earnings within an MSA belong to each spouse individually.

MSA Investments

Contributions to MSAs must be made in cash. The trustee of an MSA may be a bank, an insurance company, or other entity that will administer the trust in accordance with MSA regulations. MSA contributions may not be invested in life insurance.

Excess Contributions

An excess contribution is a contribution to an MSA which exceeds the maximum contribution amounts, or which are contributed on behalf of an individual who is not eligible for an MSA. Excess contributions are includible in gross income and are subject to an excise tax of six percent, just like

excess contributions to IRAs. If the excess contribution is removed from the MSA prior to the tax due date, the excise tax is not applied.

Distribution Rules of MSA Accounts

If distributions from MSAs are used to pay “qualified medical expenses,” the distribution is not includible in income. The distribution is tax-free.

A qualified medical expense is defined in IRC section 220(d)(2) and section 213(d):

Section 220(d)(2)

(2) Qualified medical expenses.

(A) In general. The term “qualified medical expenses” means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent... of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

Section 213(d)(1)

(1) The term “medical care” means amounts paid—

(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(B) for transportation primarily for and essential to medical care referred to in subparagraph

(A)

(C) for qualified long-term care services...

(D...or for any long-term care insurance contract...

Payment of insurance premiums is not considered a qualified medical expense except when used to pay for long-term care insurance.

MSA contributions are tax-deductible, or in the case of employer contributions, are made up of pre-tax dollars. Since the contribution amounts have never been taxed or are deducted from taxes due, when they are withdrawn for purposes other than qualified medical expenses, the entire distribution is taxable, not just the earnings portion.

Additional Tax on Distributions

If a distribution is not made for qualified medical expenses, in addition to being includible in income, an additional tax of 15% on the amount included in income distribution is also applied, unless the distribution is made after the MSA holder reaches age 65.

Medical Expense Deduction

Generally, medical expenses that exceed a certain percentage of adjusted gross income may be deducted for taxes. If an individual pays these expenses using an MSA distribution, however, these medical expenses may not be deducted.

Distributions Due to Death

Spousal Beneficiary

Upon the MSA holder’s death, if a spousal beneficiary was named, the spouse may continue the MSA as his or her own MSA. The surviving spouse may continue to contribute to the MSA, make distributions, etc., as an MSA holder.

Non-Spousal Beneficiary

If a beneficiary is named to the MSA who is not the spouse of the MSA holder, the MSA ceases to exist upon the death of the MSA holder. The fair market value of the MSA at the MSA holder’s death is includible in the gross income of the beneficiary. If no beneficiary was named, the fair market value of the MSA is includible as gross income of the deceased.

Distributions Due to Divorce

Distributions from an MSA under a divorce decree or separation agreement are not taxable. The recipient is treated as an MSA account holder, and the distribution will continue to be treated as an MSA.

Rollover Rules of the MSA

Rollovers may be made from MSA to MSA. As long as the rollover is completed within sixty days, the transaction is not subject to current taxation.

Numeric Limitations of MSAs

The Health Reform Act, which created tax-deferred MSAs, established a pilot period for the MSA program. The pilot period extends from 1997 to 2000. Generally, the maximum number of individuals who can benefit annually from an MSA is 750,000 during this period. MSA trustees must report to the IRS the number of MSAs opened in order for the IRS to monitor these numbers.

If a person establishes an MSA prior to the end of the pilot period, he or she may continue to contribute to an MSA and make distributions. If the pilot period is to be cut off earlier than the year 2000, the IRS will make an announcement no later than October 1 of the year in which MSA availability will be cut off.

During the pilot period, the Comptroller General of the U.S. must enter into a contract with an organization with expertise in health economics, health insurance markets and actuarial science to conduct a comprehensive study regarding the effects of MSAs in the small group market on:

- 1. selection (including adverse selection),*
- 2. health costs, including the impact on premiums of individuals with comprehensive coverage,*
- 3. use of preventive care*
- 4. consumer choice*
- 5. the scope of coverage of high deductible plans purchased in conjunction with an MSA and*
- 6. other relevant issues, to be submitted to the Congress by January 1, 1999*

(From the Congressional Committee Report regarding Medical Savings Accounts)

Chapter Four: Medicare and Managed Care

Medicare is a federal health insurance program. It has historically been the most expensive federally run program. New care options have been added to Medicare recently in an attempt to control expenses and provide better services to recipients. Included in these changes is the option to be covered by managed care plans.

Medicare consists of two parts, Part A, Hospital Insurance, and Part B, Supplementary Medical Insurance. Part A covers some of the expenses related to hospital, skilled nursing, home health and hospice care. Part A is provided to all eligible individuals. Payroll taxes go toward paying for Part A coverage. Part B is optional Medicare insurance. Currently, about 95% of eligible individuals are covered by Part B. Part B covers some of the expenses related to physician and outpatient services. Part B is paid for in part through monthly premiums charged to those covered by Part B. Besides the premium paid, Supplementary Medical Insurance subscribers also pay a 20% copayment for expenses covered under this program. The general revenues of the US government pay for expenses that are not covered by premiums: about three-fourths of Part B expenses.

Medicare Managed Care Plans

Managed care plans are also available to Medicare recipients. In order to be able to join a Medicare managed care plan, the Medicare recipient must be enrolled in both Part A and Part B. A recipient who has End-Stage Renal Disease, which is a permanent kidney failure with dialysis or a transplant, cannot join a Medicare managed care plan.

Medicare managed care plans must sign a contract with Medicare and agree to continue to offer the Medicare plan for one calendar year. Managed care plans generally charge premiums that the member must pay in addition to the Medicare Part B premiums due.

Medicare Hospital Insurance (Part A) Covered Services

Services	Benefit	Medicare Pays	Patient Pays
Hospitalization Semiprivate room and board, general nursing and other hospital services and supplies	<u>First 60 days</u> <u>61st to 90th day</u> <u>91st to 150th day*</u> <u>Beyond 150 days</u>	<u>All but \$768</u> <u>All but \$192 a day</u> <u>All but \$384 a day</u> Nothing	<u>\$768</u> <u>\$192 a day</u> <u>\$384 a day</u> <u>All costs</u>
Skilled Nursing Facility Care Semiprivate room and board, skilled nursing and rehabilitative services, and other services and supplies.**	<u>First 20 days</u> <u>Additional 80 days</u> <u>Beyond 100 days</u>	<u>100% of approved amount</u> <u>All but \$96 a day</u> Nothing	Nothing <u>Up to \$96 a day</u> All costs
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services	Unlimited as long as patient meets Medicare requirements for home health care benefits	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable equipment.
Post Institutional Home Health Services During A Home Health Spell of Illness Applies to those with both Part A and Part B	If patient meets Medicare requirements for this coverage, first 100 visits, then coverage for home health care through Part B.	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable equipment.
Hospice Care Pain relief, symptom management, and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
Blood When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first three pints.***

* 60 reserve days may be used only once.

** Neither Medicare nor Medigap insurance will pay for most nursing home care.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part. [This table from "Your Medicare Handbook 1997" published by the Federal Health Care Financing Administration, updated with 1999 information.]

Medicare Medical Insurance (Part B) Covered Services

Services	Benefit	Medicare Pays	Patient Pays
Medical Expenses Physician's services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment.	Unlimited services if medically necessary, except for the services of independent physical and occupational therapists.	80% of approved amount (after \$100 deductible); 50% of approved amount for most outpatient mental health services; up to 80% of \$1500 a year each for independent physical and occupational therapy.	\$100 deductible;* 20% of approved amount after deductible; charges above approved amount;** 50% for most outpatient mental health services; 20% of first \$1500 for each independent physical and occupational therapy and all charges thereafter each year.
Clinical Laboratory Services Blood tests, urinalysis, and more.	Unlimited if medically necessary	Generally 100% of approved amount.	Nothing for services.
Home Health Care*** Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services	Unlimited as long as patient meets Medicare requirements for home health care benefits	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable equipment.
Outpatient Hospital Services Services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of whatever the hospital charges (after \$100 deductible).*
Blood	Unlimited during a benefit period if medically necessary.	80% of approved amount (after \$100 deductible and starting with 4 th pint).	First 3 pints plus 20% of approved amount for additional pints (after \$100 deductible).****

* Patient pays the \$100 Part B deductible only once each year.

** Federal law limits charges for physician services.

*** Part B pays for home health care only if the patient does not have Part A of Medicare.

**** To the extent any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

This table from "Medicare 2000" published by the Federal Health Care Financing Administration

Beginning in the year 2000, those within Medicare managed care plans may withdraw from the plan at any time for any reason. If recipient does leave the plan, he or she is automatically returned to the original Medicare Plan. In the year 2002, more restrictions will be in effect regarding when a recipient may leave a plan.

Managed Care Organization Requirements to Offer Medicare Managed Care Plans

In order to enter into a Medicare contract, the managed care plan must demonstrate that it is able to enroll members and to deliver a comprehensive range of high quality services efficiently, effectively, and economically. The managed care plan's organization must meet two general requirements:

- Be approved by HCFA as an eligible organization. The organization must be either a federally qualified health maintenance organization (HMO) or a competitive medical plan, and,
- Meet Medicare's contracting requirements.

An organization eligible to offer Medicare managed care plans must be an entity that is organized under state law as either:

- A federally qualified HMO as defined in the Public Health Service Act, or
- A competitive medical plan as defined in the Act.

HMOs and competitive medical plans are compensated for health care services on a prepaid, capitated basis. There are specific requirements relating to organization and contractual arrangements, minimum benefits and health services delivery, financial arrangements, and marketing and enrollment that must be met.

An HMO is deemed to be an eligible organization if it has received federal qualification under the public health service act and such status has not been revoked.

Services Offered

In order for a competitive medical plan to offer a Medicare managed care plan, it must provide the managed care plan's enrolled commercial members at least the following services:

- Physician services performed by physicians who are doctors of medicine or osteopathy;
- Laboratory and x-ray services;
- Emergency services;
- Inpatient hospital services;
- Coverage of services while enrollees are out of the area served by the entity; and
- Preventive services.

It also must provide physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity. HCFA defines the word *primarily* as at least 51 percent of physician services, as measured either by total physician costs or by physician encounters.

Financial Risk and Viability

The plan must also assume full financial risk on a prospective basis for the health services described, although certain reinsurance and risk-sharing arrangements with providers are permitted. Reinsurance is permitted for:

- Costs exceeding \$5,000 per member in a single year;
- Costs of emergency or urgently needed care; or
- Ninety percent of the amount by which costs exceed 115 percent of the organization's income in a single year.

The plan must demonstrate financial viability by establishing:

- Total assets of the organization are greater than total unsubordinated liabilities;

- The organization has sufficient cash flow and adequate liquidity to meet obligations as they become due; and
- The organization has a net operating surplus.

The managed care plan must also maintain a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which payment is made (including inpatient care until the patient is discharged) and protection of members against bills which are the liability of the organization.

If the competitive medical plan had a Medicaid prepayment risk contract before 1970 that did not include provision of inpatient hospital services, it does not have to provide that service in order to qualify to offer Medicare managed care plans.

Differences Between HMOs and Competitive Medical Plans

There are differences between being qualified as an HMO and meeting the definition of a competitive medical plan. Federal qualification as an HMO may be received separately for purposes of commercial enrollment unrelated to Medicare, but competitive medical plan status is provided only in conjunction with a Medicare contract. The differences include:

- Federal qualification requires payment of a higher application fee for HMOs than if the managed care plan had previously contracted with Medicare as a competitive medical plan.
- HMOs must provide a more comprehensive benefit package to their commercial enrollees, such as home health care, mental health services, and substance abuse services.
- Federally qualified HMOs can *mandate an employer*. This means that if an employer offers health insurance to employees and meets certain requirements, such as having 25 employees, the HMO may require the employer to include an HMO in the company's health benefits offering. Competitive medical plans cannot *mandate employers*.
- HMOs must arrange or provide at least 90 percent of physician services through the HMO. Competitive medical plans need provide only 51 percent of physician services through physicians under contract with the competitive medical plan.
- HMOs may not *health screen* (i.e., refuse enrollment based on health status) when they enroll employer group members or when they allow members leaving the group to convert to individual memberships. Competitive medical plans may health screen commercial enrollees if permitted under state law.

Once the managed care organization is determined to be a qualified HMO or a competitive medical plan, there is no difference between the two types of organizations for purposes of the Medicare contract.

Compliance With Medicare Statutes and Regulations

In addition to meeting the requirements to become a federally qualified HMO or a competitive medical plan, the managed care organization must also meet all of the applicable requirements of the Medicare statute and regulations governing Medicare contracts. These requirements include the following:

- The plan may not enroll more than 50 percent of the managed care plan's members from a Medicare and Medicaid population.
- The plan must conduct at least one annual open enrollment period of at least 30 consecutive days.
- The plan must market the Medicare plan throughout the entire service area specified in its contract and use only marketing materials approved by HCFA. Certain marketing practices are prohibited.
- The plan must have the capability, e.g., sufficient administrative support, reporting and record keeping capacity, to meet Medicare requirements effectively and efficiently
- The plan must provide (or arrange for) at least the Medicare covered benefit package to Medicare enrollees. These services must be available, accessible, and provide for continuity

of care. The managed care plan must also assure availability of 24-hour emergency services and have provisions to pay for out-of-area unforeseen urgently needed services and emergency services not obtained through its organization.

- The plan must use only licensed physicians or providers that are certified by Medicare and suppliers that are listed with the Medicare program.
- The plan must have an acceptable quality assurance program.
- If the managed care plan wants a risk contract, it must assure HCFA that it can bear the potential financial loss.
- None of the managed care plan's agents, management staff or persons who contract with the managed care plan or have a management interest in its organization can be (or have been) convicted of a criminal offense related to his or her involvement in the Medicare, Medicaid, or other federal health or social service programs.

Monitoring of Eligibility

Once the managed care plan is approved as an eligible organization and as a Medicare contractor, HCFA monitors the organization to assure that the managed care plan continues to meet the HMO or competitive medical plan requirements as well as the specific Medicare contracting requirements. HCFA usually visits the managed care plan within the first 6 months of award and at least every other year thereafter. Desk reviews (where HCFA reviews the managed care plan's reports and other data that HCFA collects) are conducted during the intervening year. If HCFA determines that the managed care plan no longer meet these requirements, HCFA begins an evaluation process which could result in termination or nonrenewal of the plan's Medicare contract.

Medicare managed care plans are included in HCFA's beneficiary inquiry tracking system (BITS). BITS is an automated system used primarily by HCFA for tracking and monitoring of inquiries and complaints from Medicare beneficiaries and others involving Medicare approved HMOs and competitive medical plans.

BITS includes inquiries or complaints in the following areas:

- Quality of care;
- Enrollment or disenrollment problems;
- Bill payment problems; or
- Other inquiries.

The purpose of the tracking system is to assure that individual beneficiary inquiries are followed up upon. In addition, HCFA plans to use the information captured by BITS to target potential problems in HMOs and competitive medical plans and to focus HCFA monitoring efforts.

Compliance Standards

In order to contract with HCFA, the managed care plan must meet certain qualifying conditions. One of these qualifying conditions requires the managed care plan to demonstrate an ability to enroll members and to sustain a membership that ensures effective, efficient and economical care to the managed care plan's Medicare enrollees.

In order to maintain the managed care plan's contract with HCFA, the plan must comply with standards in three areas:

- operating experience and enrollment;
- composition of enrollment; and
- open enrollment.

Medicare Managed Care Plan Benefits

The plan must provide or arrange for, at a minimum, all medically necessary services (except hospice services) that are covered under Parts A and B. These services include, but are not limited to:

- Inpatient hospital care for up to 90 days in each benefit period, plus any lifetime reserve days available out of 60 total lifetime reserve days. (There is a 190 day lifetime limit for care in a Medicare certified psychiatric hospital.);
- Inpatient care in a skilled nursing facility for up to 100 days of post-hospital care for each benefit period;
- Physician services and services incident to their services, including first and second surgical opinion in the plan, manual manipulation of the spine to correct subluxation demonstrated by physician-read x-ray, and non-routine podiatric services (e.g., plantar warts and mycotic toenails);
- Outpatient physical therapy, occupational therapy, and speech pathology services;
- Ambulatory surgical center services;
- Outpatient hospital services;
- Comprehensive outpatient rehabilitation facility services;
- Home health services;
- Diagnostic laboratory, x-ray and other diagnostic tests, including portable x-rays used in the home;
- The following drugs and biologicals:
 - Blood;
 - Hemophilia clotting factors;
 - Antigens;
 - Pneumococcal vaccine;
 - Hepatitis b vaccine for persons at high or intermediate risk of contracting the disease;
 - Drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a medicare covered organ transplant is performed;
 - Effective June 1989, erythropoietin for dialysis patients who meet the medical criteria, administered either in the dialysis facility, or incident to the professional services of a physician, or, effective July 1991, self-administered by home dialysis patients; and
 - Injectable drugs for treatment of osteoporosis if the patient is homebound and cannot self-administer the drug (as certified by a physician;
- Surgical dressings, splints, casts;
- Braces, and artificial limbs and eyes;
- Prosthetic devices;
- Durable medical equipment;
- X-ray, radium and radioactive isotope therapy;
- Ambulance services when transportation by other means is contraindicated by the individual's condition;
- Treatment of end stage renal disease;
- Outpatient treatment of mental illness;
- Outpatient physical therapy and speech pathology services; and
- Screening mammography and pap smears according to a schedule based on age and risk of developing breast or cervical cancer.

Medicare also covers services in the following settings:

- Rural health clinics;
- Comprehensive outpatient rehabilitation facilities;
- Ambulatory surgical centers, but only for those service that appear on the list of covered procedures; and
- Federally qualified health centers

Normal Medicare coverage and/or payment rules may not apply in these special settings.

Medicare covers the services of the following non-physician practitioners):

- Clinical psychologists;

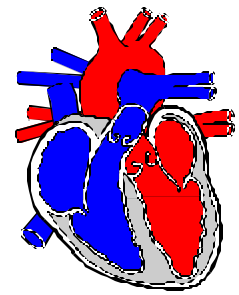
- Clinical social workers;
- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Nurse midwives; and
- Certified registered nurse anesthetists.

Transplants

The managed care plan is required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

- Kidney;
- Heart;
- Liver;
- Bone marrow; and
- Cornea.

The managed care plan is required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services.



If one of the managed care plan's Medicare enrollees is a candidate for heart or liver transplant surgery, the plan must give him or her written notification that the procedure is a covered Medicare service and that it is performed in facilities specially approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria. The managed care plan must refer enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to \$25,000 for each violation.

As benefits become covered, in some cases, they must be made available to Medicare enrollees on the effective date of Medicare coverage.

Medically Necessary Emergency Care

The plan must assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at the managed care plan facilities nor are they required to secure prior approval for emergency services provided inside or outside the managed care plan's geographic area. The plan must provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan.

Under Medicare managed care rules, *emergency services* mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

Medicare plan rules do not allow a managed care plan to deny care on an emergency-care basis if the symptoms appeared to be such that immediate medical attention was necessary. The following

examples are from Section 2104 of the *Health Maintenance Organization/ Competitive Medical Plan (HMO/CMP) Manual* published by the HCFA:

Example: while visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son - calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/competitive medical plan is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services.

There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. The plan may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then the managed care plan is not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, the plan cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, the managed care plan is not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. The managed care plan is not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, the plan must also pay the cost of medically necessary follow-up care.

Transfers

If one of the managed care plan's Medicare enrollees receives emergency medical care in a non-plan hospital, the plan may wish to transfer the patient to the managed care plan's facility (or a facility that the plan designates) as soon as possible. The plan must pay the transfer costs, such as an ambulance charge, if transfer costs are necessary.

Under the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer.

In general terms, an appropriate transfer is one in which:

- The transferring hospital:
 - Provides medical treatment to minimize the risks to the individual,
 - Forwards all relevant medical records, and
 - Uses qualified personnel and transportation equipment for the transfer;
- The receiving facility:
 - Has available space and qualified personnel, and
 - Except for specialized facilities that under the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and
- The transfer meets any other requirements the secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO or competitive medical plan.

Urgently Needed Services

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury. The plan must cover these services if:

- The enrollee is temporarily absent from the managed care plan's geographic area, and
- The receipt of health care services cannot be delayed until the enrollee returns to the managed care plan's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. The managed care plan's marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee's rights in these situations.

The following examples are from Section 2105 of the Health Maintenance Organization / Competitive Medical Plan (HMO/CMP) Manual and are regarding the plan's responsibilities related to urgently needed care:

Example: a 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

The plan must pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to the managed care plan's service area.

Services that can be foreseen are not considered urgently needed services, and the managed care plan is not required to pay for these services without prior authorization.

For example, the managed care plan is not required to pay without prior authorization when a member who needs routine dialysis or oxygen therapy travels outside the managed care plan's service area for a personal emergency or a vacation. The plan must develop a clear policy regarding

the plan's responsibility and the beneficiary's financial responsibility in these situations. The plan should consider making special arrangements with providers outside the managed care plan's service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application. Marketing materials must clearly describe the limits of the plan's out-of-area coverage.

The plan must assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in the managed care plan's plan. However, if the enrollee is absent for an extended period (beyond 90 consecutive days) and the managed care plan has not been notified and have not arranged for membership to continue, the plan may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If the managed care plan does not disenroll the beneficiary and the plan knows that he/she is absent for more than 90 consecutive days, then the managed care plan is liable for all services rendered, including routine care. (see §§2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

The managed care plan is financially responsible for services that it denies or fails to furnish that are found, upon appeal, to be services that should have been furnished.

Beneficiary Coinsurance Amount

If the managed care plan is a risk HMO or competitive medical plan, the sum of the managed care plan's charges for copayments, coinsurance, or deductibles may not exceed, on the average, the national actuarial value of the coinsurance and deductible amounts the beneficiary would have paid had he or she not been enrolled in a Medicare contracting plan.

While the plan may negotiate lower payment amounts with providers and suppliers, it is ultimately the managed care plan's responsibility to assume full financial responsibility for the services. The plan must assure that the beneficiary has no liability beyond any approved copayments.

Similarly, if the plan is determined, upon appeal, to be liable for services that a beneficiary obtained without authorization because the plan improperly denied coverage, the beneficiary does not have liability for any balance billing from the provider of such services. In this instance also, the managed care plan is liable for paying the full charges or paying whatever amount the plan can negotiate with the provider as payment in full. The beneficiary is only liable to the plan for copayments or other beneficiary liability amounts approved as part of the managed care plan's Medicare contract.

Supplemental Benefits Subject to Premium

The plan may also offer supplemental benefits that are beyond the scope of Medicare coverage. Enrollees may be charged an additional premium over and above the amounts which may be charged to cover Medicare deductible and coinsurance amounts. The amounts charged to cover supplemental services must be separately identified and may not exceed certain maximum amounts.

Prohibition on Health Screening

Except as provided below, the plan may not require a Medicare enrollee, as part of enrollment, reenrollment or receipt of any services, to submit to or pass a health examination. This prohibition on health screening applies to any service or set of services offered to Medicare enrollees, whether they are required services under Medicare, additional services, or mandatory or optional supplemental services. There are penalties specified in the law for violations of the health screening prohibitions.

Exceptions:

The plan may not enroll persons who have been medically determined to have end stage renal disease or who have elected the Medicare hospice benefit (unless they are already enrolled in the

organization and convert to the Medicare contract when they become Medicare eligible, in which case the plan may not disenroll them).

Services Authorized by a Plan Physician

The plan must ensure that physicians or providers know whether services are covered by Medicare or by the managed care plan as an additional or supplemental benefit, and that they properly use the authorization system that is established. If a Medicare beneficiary receives services under the direction or authorization of a *plan physician*, who is any physician who contracts with an HMO or competitive medical plan or is otherwise associated with the HMO or competitive medical plan, and the beneficiary has not been informed that he or she is liable for the costs of such services, then the plan must pay for such services. The plan may not, after the service is received, overturn a plan physician's decision that a service is medically reasonable and necessary. The plan may not deny coverage retroactively for a service ordered by a plan physician based upon a determination that the service exceeds Medicare limits, e.g., that it was a custodial rather than a skilled nursing service.

The only exceptions to these instruction are (1) the presence of written evidence (including clear specification of non-coverage in marketing material) that the HMO physician advises the beneficiary before each and every service is received that the service is not covered unless further action is taken by the member and (2) cases where the beneficiary should be expected to know the services were not covered by Medicare, e.g., for acupuncture. The plan may require the Medicare enrollee to receive prior authorization from a primary care physician or a gatekeeper before specialty care is received.

If one of the plan's physicians provides or directs a beneficiary to receive a covered Medicare service without following the managed care plan's internal procedures, the plan must pay for the service. The plan may not penalize a beneficiary who has already received a service if the authorizing physician's referral was improper or the specialist delivered the service without the necessary authorization

Availability, Accessibility And Continuity Of Services

All medically necessary Medicare covered services, supplemental services, and additional benefits must be available and accessible with reasonable promptness to Medicare members.

The provider networks for Medicare enrollees must be sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in the managed care plan or to make appropriate referrals. If the plan loses providers in a portion of the service area during the contract year, the plan must still assure the provision of covered services.

The provider networks for Medicare enrollees must be from the same networks that the plan uses for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers.

Marketing materials must clearly state providers or physicians currently available to Medicare members and those accepting new patients.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally, this is within 30 minutes travel time from the Medicare beneficiary's residence. Exceptions may be made if the usual travel patterns for medical care exceed 30 minutes.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week.

Continuity Of Care

Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes linkages between primary and specialty care, coordination among specialists, appropriate

combinations of prescribed medications, coordinated use of ancillary services, appropriate discharge planning, and timely placement at different levels of care including hospital, skilled nursing and home health care. HCFA recommends that the plan develop a comprehensive treatment plan for the overall health maintenance and management of each Medicare beneficiary. The plan should include any treatment modalities that are employed to offset any illness and related medical conditions. The plan should also include treatment at the proper level of care and assure adequate follow-up for the health maintenance of each beneficiary.

The plan must also provide a basic system for continuity of care and case management. This may be established through reliance on a primary physician who serves as an enrollee's case coordinator. The plan must establish and maintain a record keeping system that includes health and medical information on each Medicare enrollee. The plan must also assure that the system is readily available to appropriate professionals.

Managed Care Plan Arrangements for Health Services

The managed care plan's health care providers and suppliers must meet applicable Medicare regulations and be certified for participation in the Medicare program. The managed care plan's arrangements with providers and suppliers must assure that health services are available and accessible to all of the managed care plan's members and must promote continuity of health care. Also, the plan must assure that participating providers and suppliers follow the managed care plan's programs and procedures. Typical contracts include provisions for:

- Participation by providers and suppliers in the HMO or competitive medical plan's quality assurance and utilization review programs,
- Medical coverage after office hours and during absences,
- Cooperation with peer review organizations for purposes of medical record review,
- Incentive or risk sharing arrangements,
- Types of services to be provided,
- Treatment for Medicare enrollees, and
- Adherence to the managed care plan's medical policies.

Hospital And Nursing Facility Services

The plan or the managed care plan's affiliated providers/suppliers must arrange or provide all hospital services except when:

- Emergencies occur outside the service area,
- Emergencies occur within the area that result in treatment at a non-affiliated hospital, or
- Urgently needed services occur out of the area.

The managed care plan is responsible for paying for services in these three situations.

The plan must furnish the required hospital services to Medicare enrollees through hospitals that meet conditions of Medicare participation. Criteria for hospital participation are:

- Compliance with federal laws and regulations relating to the health and safety of patients,
- State licensure, and
- Assurance that hospital personnel have credentials required by federal, state or local laws.

An HMO or competitive medical plan must also have arrangements for skilled nursing services. These services are provided through skilled nursing facilities that must meet conditions of Medicare participation.

Hospital Admitting Privileges

The managed care plan's primary care physicians and specialists must have hospital admitting privileges to at least one of the hospitals with which the managed care plan has arrangements. Also, the hospitals in which the physicians are privileged must serve the area from which the physicians draw the managed care plan's enrollees.

Professional Services

Medicare benefits provided by licensed health professionals, including physicians, must be provided or arranged through:

- Physicians or health professionals who are on the managed care plan's staff,
- A medical group or groups,
- One or more individual practice associations (IPAs),
- Physicians or health professionals under direct service contracts with the plan, or
- Any combination of the above.

In order to provide services at the most efficient and cost effective level, the plan may enter into arrangements with other health professionals who are licensed, certified, or practice under an institutional license, or other authority consistent with state law. For example, if a health service provided by a physician may also be provided under applicable state law by a dentist, optometrist, chiropractor or other health care personnel, the plan may have these professionals provide this service. However, all providers and suppliers rendering services to Medicare enrollees must be Medicare certified.

For services performed by non-physicians, direct physician supervision of such services is required. The supervising physician or physicians must be available during office hours to perform medical rather than administrative services. In an HMO or competitive medical plan setting, the following practitioners are excepted from the physician supervision requirement under certain circumstances:

- Physician assistants,
- Nurse practitioners,
- Clinical psychologists,
- Certified nurse midwives,
- Clinical social workers, and
- Registered nurse anesthetists.

Availability and Accessibility of Services

The plan must assure that all Medicare covered services, supplemental services, and additional benefits that members have contracted for in the managed care plan's geographic area are available and accessible. The managed care plan's geographic area is the contract area, approved by HCFA, in which the plan provide or arrange for the provision of health services and in which the plan enroll Medicare members.

The plan must construct provider and supplier networks or make arrangements for referrals for Medicare enrollees sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in the managed care plan. Marketing materials and other member information must include a description of the managed care plan's participating providers and suppliers as well as the managed care plan's contract area.

Services must be available and accessible with reasonable promptness with respect to geographic location, hours of operation, and provision for after hours care. Providers and suppliers must be located throughout the geographic area.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally hospital and primary care physician services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care physician services exceed 30 minutes. For example, travel time might be greater than 30 minutes in a rural area.

The provider and supplier networks for Medicare enrollees must be the same that the plan uses for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers and suppliers. This does not restrict some

providers and suppliers from treating only Medicare enrollees as the result of non-Medicare enrollees not choosing certain providers and suppliers, location in a senior center, or the nature of a supplier's practice (e.g., gerontologists).

If the plan loses physicians in a portion of the service area during the contract year, the managed care plan is still responsible for assuring the provision of covered services. The plan must inform members, in writing, 30 days before a physician or supplier terminates affiliation.

Some physicians and other providers in the managed care plan's network may go through periods of time when they are not accepting new patients. The plan must state in the managed care plan's marketing materials which physicians and providers are not accepting new patients. These materials must be updated annually or more frequently as changes in the managed care plan's provider and supplier network take place.

Generally, if a Medicare certified facility such as a skilled nursing facility is not available in the managed care plan's area, the managed care plan is still responsible for providing Medicare-covered services.

If a provider (i.e. Hospital, skilled nursing facility or other entity having a Medicare provider agreement under the Act) chooses not to admit the managed care plan's Medicare enrollees, then the HMO may not refer its commercial enrollees to this provider. Providers may apply any restriction on admission that is not otherwise prohibited by state or federal law, but only if the restriction is applied the same way to non-Medicare beneficiaries as it is to Medicare beneficiaries. A hospital or skilled nursing facility can refuse to admit a Medicare HMO or competitive medical plan enrollee (except in emergencies) if the same criteria for denying admission are applied equally to all enrollees (of the HMO or competitive medical plan) seeking admission, regardless of their Medicare entitlement.

Accessibility and Hours of Operation

Hours of operation for health services for membership must be convenient to the population served and must reflect patterns of care in the managed care plan's geographic area. The plan must make provisions for after hours care, including emergency care.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week. Member information must include a clear definition of a medical emergency and the procedures for obtaining care in such a situation. Specifically, these materials must address how to obtain care or authorization:

- During office hours in the service area,
- After office hours in the service area, and
- Outside of the service area.

Monitoring

The plan must have systems in place to collect data to evaluate the availability and accessibility of services that plan provides or arranges. Specifically, these systems monitor factors such as the following:

- Waiting times to obtain appointments for routine scheduled and urgent care,
- Waiting times to receive services at physician offices and clinical and diagnostic facilities,
- Procedures for receiving and analyzing member complaints,
- Telephone access to the plan and primary care physician for routine and urgent care, as well as in emergencies, both during and after office hours,
- Inappropriate use of emergency services as an indication of lack of availability and accessibility of plan services,
- Number of requests as well as reason for requests to change primary care physicians,
- Number of physician requests to close their practice to new patients,

- Physician back-up and on-call arrangements for primary care physicians, and
- Volume of out-of-plan referrals by specialty and service.

Monitoring availability and accessibility of care can be done through:

- Surveying physician offices and other plan facilities initially and on a continued routine basis,
- Surveying promptness of services at physician offices and other plan facilities with feedback to the offices and facilities surveyed,
- Tracking physician turnover and the stability of the provider/supplier network,
- Surveying waiting times for an appointment at physician offices and other plan facilities with feedback to these offices and facilities,
- Reviewing appointment scheduling procedures,
- Reviewing member complaints on availability, accessibility and other quality of care issues, and
- Analyzing the system used to determine the need for additional providers/suppliers and the system for recruiting.

Continuity of Care

Continuity of care is the degree to which the care needed by a patient is coordinated effectively among practitioners across provider organizations over time. This concept emphasizes:

- Coordination of health care services among primary and specialty care physicians,
- Coordination among specialists,
- Appropriate combinations of prescribed medications,
- Coordinated use of ancillary services, including social services and other community resources,
- Appropriate discharge planning, and
- Timely placement at different levels of care, including hospital, skilled nursing facility and home health care.

Services provided to members must be structured in a manner that assures continuity. The plan can achieve this by having a primary physician responsible for coordinating a member's overall health care and by maintaining record keeping systems through which pertinent information relating to the health care of the member is accumulated and readily available and shared among appropriate professionals and available for external peer review. The plan must make arrangements for the physician or other health professional coordinating the members overall health care to be kept informed about referral services provided to members.

The plan must also employ systems to promote continuity of care and case management. This could include development of a plan for the overall treatment of each patient. The plan could cover the full course of illness and related medical conditions. It should also address issues related to treatment at the proper level of care and ensure adequate follow-up.

Coverage Under Medicare Managed Care Plans

There are several positive aspects related to Medicare managed care plans. All care is covered through the plans, not just the care covered through the Original Medicare Plan. Extra services are generally provided as well, including:

- Eye exams
- Discounts for eyeglasses
- Annual well-patient physicals
- Annual mammograms

Some plans also provide basic dental coverage. Besides these advantages, enrollees may be attracted to Medicare managed care plans because the managed care plan will screen the physicians who provide care within the plan.

Disadvantages related to Medicare managed care plans include the necessity of getting physician referrals in order to see a specialist. The ability to enroll in a plan and receive treatment may be restricted to a certain geographic territory. In addition, as with all managed care plans, physicians are generally given incentives to see patients as few times as possible.

Additional concerns related to Medicare managed care plans include the fact that plans may withdraw from participation after twelve months. This can leave a patient at the least inconvenienced and at the most, left the ability to continue care under a trusted physician.

Another concern is that although plans are prohibited from health screening in order to deny Medicare applicants coverage, it has been claimed that some plans eliminate higher risk patients by providing poor service to them.

Medigap Standard Policies

Before Medicare rules allowed recipients to enroll in Medicare managed care plans, they were limited to using Medigap insurance policies. Medigap insurance policies, as their name suggests, are designed to fill the *gaps* Medicare coverage leaves. These policies are designed to pay items such as Medicare coinsurance amounts and Medicare deductibles and to provide coverage for services not paid for by Medicare. Some Medigap policies will pay for the amount charged for services above the Medicare-approved amount. Medigap insurance policies vary in the scope of coverage they provide. Premiums for Medigap insurance are generally more expensive than premiums required for Medicare managed care plans, and the broader the coverage the Medigap policy provides, the more expensive the premium.

OBRA Medigap Legislation

The Omnibus Budget Reform Act of 1990 (OBRA '90) included legislation to prohibit the practice of any insurer from offering any policy that duplicates Medicare coverage. This practice was prohibited because it resulted in the insured paying premiums to the insurer for coverage he or she would receive through Medicare.

OBRA 1990 also changed the structure under which commissions are paid on Medigap policies. First year commissions on Medigap policies may not be greater than twice the second year's commissions, and the second through fifty year commission must be equal. States may also have additional regulations regarding Medigap policy commissions. If a Medicare recipient is enrolled in a Medicare managed care plan, the recipient may keep any Medigap policy he or she has. The Medigap policy only applies when a recipient is on the original Medicare plan.

There are ten standard Medigap policy types. The federal government, in cooperation with the states, required these ten plans in part to assist consumers from being confused by too many plan options. Insurers offering the standard plans are required to use the same language, format and definitions in Medigap insurance policies. A standardized chart and outline of coverage is also required for all Medigap providers.

Policies issued to residents of Minnesota, Massachusetts and Wisconsin are exempt from the requirements of the standardized plans. These states had Medigap plans in place prior to the passing of federal regulations that the regulators determined did not have to change.

The ten basic Medigap policies are identified as plans A to J. The dollar figures noted in the following plan descriptions are subject to change.

Medigap Plan A –Basic Policy

The benefits under the Medigap Basic Policy include:

- Coverage for the Part A coinsurance amount for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- Coverage for 100% of Medicare Part A eligible hospital expenses after all Medicare hospital benefits are exhausted. The coverage limit is a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. The benefit is paid either at the rate Medicare pays hospitals under the Prospective Payment System (PPS), or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services after the \$100 annual deductible is met.

Medigap Plan B

Plan B includes the same benefits as Plan A, plus coverage for the Medicare Part A inpatient hospital deductible.

Medigap Plan C

Plan C includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

Medigap Plan D

Plan D includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to \$1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Medigap Plan E

Plan E includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B excess charges. The plan pays a specified percentage of the difference between the Medicare-approved amount for Part B services and the actual charges, up to an amount of charges limited either by state regulation or by Medicare.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible. This benefit has a \$50,000 lifetime maximum.
- Coverage for at-home recovery. The at-home recovery benefit pays up to \$1600 per year for short-term, at-home assistance with activities of daily living.

Medigap Plan F

Plan F includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges (as explained under Plan E).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for services such as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.
- Coverage for at-home recovery. The at-home recovery benefit pays up to \$1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.
- Coverage for an extended drug benefit. This provision pays 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible.
- A future high deductible option.

Medigap Plan G

Plan G includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for 80% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to \$1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Medigap Plan H

Plan H includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for an extended drug benefit. This provision pays 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible.

Medigap Plan I

Plan I includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for services such as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

Medigap Plan J

Plan J includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for 100% of Medicare Plan B excess charges.
- A future high deductible option.

An insurer may offer benefits in addition to a standardized plan. Federal law allows an insurer to add “new and innovative benefits” to Medigap policies. Any such additional benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplifying Medigap insurance.

Enrollment in Medigap Policies

Any person who is age 65 or older and has enrolled in Medicare Part B has a right to buy a Medigap policy regardless of health. This open enrollment period lasts for six months from the date these two conditions are met. During open enrollment, the Medigap insurer cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of the insured’s medical history, health status or claims experience. If an insured enrolls in a Medigap policy outside of this open enrollment period, however, the insurer can apply any pre-existing condition restrictions that are normally part of the policy.

Beginning July 1, 1998, Medigap policies cannot apply pre-existing condition provisions to anyone who is age 65 or over and has had Medigap or qualified employer health insurance continuously for at least six months.

Medigap Policies and Health Care Continuation

In most states, if a person is 65 or older and if his or her health insurance is discontinued under one of the circumstances below, the person is guaranteed the ability to buy a Medigap policy.

The conditions under which this guarantee applies include any of the following situations:

- The insured was enrolled in an employer group health plan with benefits that supplement Medicare benefits and the plan stopped providing those benefits.
- The insured was enrolled in a Medicare Health Maintenance Organization, Health Care Prepayment Plan, or Medicare SELECT policy and the insured’s enrollment ended due to the insured moving outside of the plan’s service area, or because the plan’s contract with Medicare ended, or because the insured elected to leave the plan.
- The insured enrolled in a Medigap policy and coverage stopped because of the insolvency of the company, because of other involuntary termination of coverage (and there is no State law for continuing that coverage), or the company violated or misrepresented a provision of the policy.

If one of these situations apply and the insured applies for the new policy within 63 days of losing health coverage, the insured is guaranteed to be able to buy a new Medicare supplemental policy if:

- the insured was enrolled in Medicare, or
- if the insured had a Medigap policy and dropped it to enroll in a Medicare managed care or Medicare SELECT policy for the first time, or
- if the insured chose to disenroll from the Medicare HMO or Medicare SELECT policy within 12 months of first enrolling.

Under this guarantee, an insurer may sell the insured Medigap Plan A, B, C or F. All Medigap providers sell Plan A, and those who normally sell plans B, C or F must offer these plans to persons to whom this guarantee is applicable.

Medicare SELECT Policies

Medicare SELECT policies are very similar to the standard Medigap policies. The important difference between SELECT policies and Medigap policies is that the insurer offering the plan requires that the insured must use specific hospitals, and in some cases, specific doctors, in order to be covered by the insurance. Emergency services are generally exempted from this requirement under these policies. Because SELECT policies use *preferred providers* the insurance premiums are normally lower than comparable Medigap policies.

The Medicare+Choice MSA

The Budget Act of 1997 introduced the Medicare+Choice MSA. The Medicare+Choice MSA, or Medicare MSA, allows a Medicare recipient to instruct the Secretary of Health and Human Services to make contributions to a Medicare MSA. Distributions from the Medicare MSA are used to pay qualified medical expenses rather than having Medicare pay these expenses. If distributions are used for this purpose, the distributions are tax-free. The Medicare MSA became available in 1999. Like other MSAs, the Medicare MSA can be used in conjunction with managed care plans.

The reason Congress created the Medicare+Choice MSA is to decrease the costs of the Medicare program, or at least to slow down the increases in Medicare spending. If individuals are made responsible for their own health expenditures, and if they are given a tax incentive to keep medical expenditures down, Congress reasoned, the growth of Medicare spending will be “tempered.” Besides the issue of expenses, Medicare+Choice MSAs give senior citizens more choice regarding their health care.

Eligibility and Contribution Rules of the Medicare MSA

Eligibility

Individuals on Medicare are eligible for the Medicare MSA. Generally, this includes individuals who are 65 or older, those who are permanently and totally disabled, and certain individuals with specific diseases that Medicare covers.

Contributions

Contributions to Medicare MSAs are made by the Secretary of Health and Human Services. The Secretary pays for a high-deductible insurance policy, and also makes a contribution to the Medicare MSA for the eligible individual. When the Medicare MSA laws were passed, it was estimated that the contribution to a Medicare MSA would be between \$1500 to \$2100 per year. Contributions are not includible in the income of the Medicare MSA holder.

Medicare MSA High-Deductible Insurance Policy Requirements

Under Medicare MSA rules, the high-deductible insurance policy must provide reimbursement for services covered by Medicare Parts A and B, after a deductible of not more than \$2,250 and not less than \$1,500, in 1999. These levels are indexed for inflation after 1999. The individual Medicare MSA holder chooses the high-deductible plan that will be used in conjunction with the Medicare MSA. The Medicare MSA plan must also include a cap of \$3000 in out-of-pocket expenses.

Medicare MSA Trustee

The trustee of a Medicare MSA can be a bank, insurance company or other entity which will administer the MSA in accordance with Medicare MSA rules.

Medicare MSA Investments

Medicare MSAs may not be invested in life insurance.

Excess Contributions

Like other MSAs and IRAs, if an excess contribution is made to a Medicare MSA, an excise tax of 6% is due on the excess contribution.

Distribution Rules Of Medicare MSAs

If distributions of Medicare MSAs are used for qualified medical expenses, the distribution is not taxable. The definition of qualified medical expenses for a Medicare MSA is the same as that for other MSAs, except that qualified medical expenses do not include payment of medical expenses for anyone except the individual MSA holder. Medical expenses of a spouse or dependent are not qualified medical expenses under Medicare+Choice MSA rules.

Additional Tax on Distributions

Any distribution which is not for a qualified medical expense is subject to an additional tax of 50% on the excess of :

- (i) *the amount of the payment or distribution, over*
- (ii) *the excess (if any) of:*
 - (I) *the fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over*
 - (II) *an amount equal to 60 percent of the deductible under the Medicare+Choice MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.*

The exceptions to this tax are distributions that are due to death or due to disability.

The 15% additional tax that applies to non-qualified medical expense distributions of regular MSAs does not apply to Medicare MSAs.

Distributions Due to Death

Spousal Beneficiary

If a spousal beneficiary is named on a Medicare MSA, the surviving spouse is treated as the Medicare MSA holder.

Non-Spousal Beneficiary

If a non-spousal beneficiary is named on a Medicare MSA, the MSA ends upon the death of the Medicare MSA holder. The value of the Medicare MSA is includible in the gross income of the beneficiary in the year of death of the MSA holder. If no beneficiary is named, the value of the Medicare MSA is includible in the gross income of the deceased when the final tax return is calculated.

Distributions Due to Divorce

The same rules applied to regular MSAs regarding distributions due to divorce apply to Medicare MSAs. Distributions from an MSA under a divorce decree or separation agreement are not taxable. The recipient is treated as an MSA account holder, and the distribution will continue to be treated as an MSA.

Trustee-to-Trustee Transfers

A trustee-to-trustee transfer from one Medicare MSA to another for the same account holder is not considered a taxable transaction. A trustee-to-trustee transfer is a distribution that is made directly from the trustee or administrator of an MSA account to another trustee or administrator of an MSA account.

Medicare Patients Bill of Rights

Medicare recipients have their own Patients Bill of Rights. The issues involved in these rights are many of the same issues dealt with in the Patients Bill of Rights that Congress has considered for managed care members outside of Medicare. The rights are as follows, as listed in the *Medicare & You 2000 Handbook*, published by the Health Care Financing Administration:

If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan or a Medicare managed care plan.

- *You have the right to get emergency care when and where you need it, without prior approval. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.*
- *You have the right to appeal if Medicare does not pay for a covered service you have been given, or if your doctor or hospital does not give you a service that you believe should be covered.*
- *You have the right to know all your treatment options from your health care provider in language that is clear to you. Medicare must give you information about what is covered and how much you have to pay. Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.*
- *You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. The law requires Medicare to keep this information private. When Medicare asks for this kind of information, we must tell you that the law lets us collect it for payment and health treatment purposes. You have the right to know why we need it, whether it is required or optional, what happens if you don't give the information, and how it will be used..*
- *You have a right to choose a women's health specialist from your plan's list of doctors to meet your women's health care needs.*
- *If you have a complex or serious medical condition, you have a right to have enough visits to a specialist to deal with your needs.*
- *You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, a lab that he or she refers you to for a blood test.*
- *If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may either file a grievance with your plan or with the Peer Review Organization (PRO) in your State.*
- *You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal. If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.*
- *If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think*

your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

- *The Medicare managed care plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.*

Chapter Five: Current Issues and Trends In Managed Care

This course has touched on many of the issues and debates surrounding managed care. Although other parts of the insurance industry have had their share of controversies – liability and tort laws involved in automobile, homeowners and professional liability insurance, for example – the health insurance and managed care industries have been the subject of the hottest and most passionate discussions regarding personal coverage in recent years. Health care coverage affects everyone in our society. It involves human lives, not just human pocketbooks, unlike many other forms of insurance coverage. Because it matters so much to us all, the public debate regarding health and managed care stirs up a tremendous amount of interest.

Matters of Debate



The structure and administration of managed care include many facets. Health care advocates, plan members, politicians, and other public leaders are discussing each of these facets today. Each facet has become a matter of debate.

For Profit vs. Non-Profit

One of managed care elements being debated involves the presence of both *for-profit* and *non-profit* managed care organizations. It is believed by some that all health care organizations should operate as non-profit organizations. If the profit motive is removed, it is argued, the tendency to either over prescribe or under prescribe treatment to patients will be removed. Corporations interested in making money and theoretically uninterested in providing adequate care will be removed from the health care industry, along with their “greedy” ideals.

Those who believe in profit making health care organizations counter these arguments by noting that physicians are still paid compensation when working for non-profits and can either work hard and well or work little and inefficiently regardless of for whom they are working. In addition, they argue, if the competitive forces associated with for-profit enterprises are eliminated from health care, it is possible that those non-profit organizations and physicians who provide poor care will remain in the industry longer than if they operated on a for-profit basis. Those who are for a free market approach in health care believe that the market acts as both a moral and economic check on businesses operating within it because the will of the people, who are the market, is made known through marketplace choice.

Physician-Run vs. Non-Medical Personnel-Run Health Organizations

Another issue that divides people regarding managed care structure is the presence of non-medical entities running managed care plans. Physicians have raised objections about non-medical personnel overseeing their decisions. It is also illegal for non-licensed people to provide medical advice. Some managed care plans not run by medical personnel seemingly walk a fine line in order to avoid being medically and legally responsible for the care given under their plans. They structure the plans so that utilization review is performed by medical personnel, use formularies and other treatment tools based on medically recognized and approved methods, and word the contracts with

physicians to ensure the physicians have appropriate medical discretion and the associated liability to prescribe care. However, physicians within some plans have stated that they have been made to feel pressured to limit care or to prescribe certain types of treatment by managed care organizations.

Probably the biggest debate related to this issue is whether managed care organizations should be held legally liable for care received under their plans. On one side of this issue are those who believe members should be able to sue managed care organizations for damages as the result of care received. On the other side are years of legal precedence that place the responsibility for care on the caregiver – on the physician, hospital or other health care provider.

Privately-Funded Health Care vs. Government-Funded Health Care

National health care has been discussed since organized health care began in the late 1800's. The numbers and strength of its proponents has waxed and waned, but it has been an on-going issue in the United States for decades. Those who support national, government-sponsored health care point to the impoverished, the elderly, the sick, the disabled, to single parents and their children who are uninsured, underinsured or denied access to health care through normal market channels. National health care, they argue, will ensure those less fortunate will be taken care of. Adequate health care is a right, not a privilege, is a philosophy carried by many who voice a desire for national health care.

Another argument held by those who are dissatisfied with the current health care system and believe the government should take the reins is that government control would alleviate the personal interests that lead to making decisions based on making money. The government could gather all the talented and educated in the medical community and put together and apply standardized treatments for standardized payments so that everyone could get equally good medical care, regardless of where they lived, who they were, and how much money they had.

Those against government sponsored nation health care believe that the costs of care will go up and the quality will go down under such a system. Bureaucracy will eat up premiums that are needed to cover costs of adequate care. Government created formularies and required treatments will replace physician discretion. Technological innovations in the medical field will diminish for lack of funding. Treatments available through alternative medicine will take longer to be approved under government-sponsored programs. Opponents believe that less qualified students will apply to medical school because the overall working environment for a physician will diminish, as will opportunities for the type of compensation physicians have today and have had in the past. Medical students will be discouraged from taking the loans necessary to finish a medical degree because they won't be compensated enough under a national health care system to pay them off. This scenario continues on to predicting that prestigious medical universities will no longer be able to offer the type of medical training they offer today due to reduction in enrollment.

Besides believing there will be a reduction in the number of qualified physicians and fewer technological advances, opponents of national health care believe the population will not be able to bear the financial taxation burden required in order to provide health care for everyone. Citizens will also experience more interference in their private lives as government attempts to reduce costs of care by banning foodstuffs and activities deemed to lead to obesity or other health hazards. A city in Florida recently required coffee shops to stop offering a coffee beverage with a high cream content because it could lead to heart disease and obesity. Some of those against national health care believe such bans would become more common should government-sponsored health care programs increase.

Many opponents to national health care believe that the poorer people in society are better off with a private health care industry, since charitable organizations now have donations of both time and money contributed by medical care establishments, physicians, researchers and others in the relatively affluent medical community today. If health care money is used up in bureaucracy and

inefficiency, they argue, charitable organizations involved in both medical research and medical care may no longer be able to offer quality care services to the needy.

Technological Opportunities vs. Cost Control

Another important issue regarding health and managed care involve the difficulties encountered because the technological ability of medicine has outpaced the affordability and resources needed to implement such advances. Transplants of most organs now may be performed successfully. People with terminal illnesses can have their lives prolonged. Those with physical disabilities can be equipped with amazing machines to reduce the effect of the disability on their lives. However, all these new technological miracles cost money and may require scarce resources, such as organs from donors. Those in the medical community must wrestle with trying to determine what care is adequate and reasonable. Trying to provide the best care possible becomes continually more difficult because the best keeps getting better.

The Role of the Employer vs. The Role of the Individual

Employers arranged for the first managed care plans and continue to be the primary force in the industry today. Employers must balance their concerns for the welfare of their employees with their responsibilities of running a profitable business. They must provide competitive wages and benefits, yet do not want to offer significantly more compensation than their competition and risk hurting their business by using money for compensation rather than other important business needs. They do not want to offer significantly less compensation than their competition and risk losing good employees. Managing health care expenses is an important concern of employers today.

If employers want to be able to offer and deduct the cost of employee health benefits for federal tax purposes, they must follow federal and state rules in the administration of these plans. In return for a tax benefit, or depending on one's point of view, the lack of a tax penalty, an employer must submit to federal regulation of group health plans. Some health care advocates believe that the increase in federal and state regulation as it pertains to employer sponsored health plans is a leading contributing factor to the increases in health care costs over the last decade.

Some propose that employers stop providing health benefits to employees and instead increase employee wages in amounts equal to what they pay for health care. By allowing employees to purchase their own health care coverage, or to decide not to, would cause government intervention to diminish and so significantly reduce many of the expenses related to health care. Opponents of such ideas do not believe employees would make the decision to purchase health care coverage and say that if employers do not provide health benefits, workers would fall ill, be uninsured, be unable to afford treatment, stay ill, lose their jobs, and fall onto welfare rolls, not to mention ruin their family's and their own lives. Under this point of view, requiring employers of a certain size to take care of employees protects employees from their own lack of forethought and discipline. It is also argued that without employers to obtain group coverage, health coverage premiums will rise. People on the other side of the issue say that other, private sponsors would rise up and work with managed care organizations or insurers to offer group coverage.

Patients' Bill of Rights

In 1998, Senators Tom Daschle and Ted Kennedy introduced Senate Bill 1890, the Patients' Bill of Rights. The Bill addressed many concerns the public has regarding managed care and health care in general. The Bill was a sweeping attempt to require health plans to provide care in a manner prescribed by the federal government. It is instructive to review some of the Bill's key provisions. The Bill's provisions reflect complaints and concerns the public has made about the methods through which health care is provided today. This Bill is an excellent example of the issues lawmakers are debating regarding managed care, and health care in general. We can expect that the issues within this Bill will continue to be discussed by regulators and that many of its provisions are likely to be passed into law, or that the ideas behind the provisions will be voluntarily adopted by managed care plans.

Some of the requirements within the Bill are already in place in many managed care plans. For example, the Bill requires that an internal appeals process be in place, and many managed care plans already have such processes. The Bill also requires an internal quality assurance program, and many managed care plans already have a system to monitor the quality of services provided.

Other requirements are not in place today. The Bill requires that external appeal entities be established. The external appeal entities must meet several requirements and must be certified by the Secretary of Labor or by a state agency. This requirement would add significant government influence on the managed care environment.

Below is the table of contents for the Bill. As can be seen, the Bill addresses many key elements of health care plans. It also includes many of the components found in Medicare managed care plan rules.

Title I—Health Insurance Bill Of Rights

Subtitle A—Access to Care

Sec. 101. Access to emergency care.

Sec. 102. Offering of choice of coverage options under group health plans.

Sec. 103. Choice of providers.

Sec. 104. Access to specialty care.

Sec. 105. Continuity of care.

Sec. 106. Coverage for individuals participating in approved clinical trials.

Sec. 107. Access to needed prescription drugs.

Sec. 108. Adequacy of provider network.

Sec. 109. Nondiscrimination in delivery of services.

Subtitle B—Quality Assurance

Sec. 111. Internal quality assurance program.

Sec. 112. Collection of standardized data.

Sec. 113. Process for selection of providers.

Sec. 114. Drug utilization program.

Sec. 115. Standards for utilization review activities.

Sec. 116. Health Care Quality Advisory Board.

Subtitle C—Patient Information

Sec. 121. Patient information.

Sec. 122. Protection of patient confidentiality.

Sec. 123. Health insurance ombudsmen.

Subtitle D—Grievance and Appeals Procedures

Sec. 131. Establishment of grievance process.

Sec. 132. Internal appeals of adverse determinations.

Sec. 133. External appeals of adverse determinations.

Subtitle E—Protecting the Doctor-Patient Relationship

Sec. 141. Prohibition of interference with certain medical communications.

Sec. 142. Prohibition against transfer of indemnification or improper incentive arrangements.

Sec. 143. Additional rules regarding participation of health care professionals.

Sec. 144. Protection for patient advocacy.

Subtitle F—Promoting Good Medical Practice

Sec. 151. Promoting good medical practice.

Sec. 152. Standards relating to benefits for certain breast cancer treatment.

Sec. 153. Standards relating to benefits for reconstructive breast surgery.

Subtitle G—Definitions

Sec. 191. Definitions.

Sec. 192. Preemption; State flexibility; construction.

Sec. 193. Regulations.

Title II—Application Of Patient Protection Standards To Group Health Plans And Health Insurance Coverage Under Public Health Service Act

Sec. 201. Application to group health plans and group health insurance coverage.

Sec. 202. Application to individual health insurance coverage.

Title III—Amendments To The Employee Retirement Income Security Act Of 1974

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

Title IV—Effective Dates; Coordination In Implementation.

Sec. 401. Effective dates.

Sec. 402. Coordination in implementation.

Under the Access to Care provisions in Subtitle A, prior authorization of emergency care is prohibited. Emergency care, including non-network emergency care, is covered based on the *prudent layperson* standard, meaning that if the symptoms appear to warrant emergency care, the care is covered. Currently, a health plan can deny coverage for emergency care once a diagnosis is made and the patient did not actually need emergency care. Under the Bill, non-network emergency care could not be covered for a lesser amount than network provided emergency care. Plans would also have to cover necessary post-stabilization and maintenance care because such care is covered under Medicare guidelines.

Under the Coverage Options of the Bill, if an employer offers only a single health plan, and the plan is an HMO, the employer must also offer employees the opportunity to purchase a POS plan in addition to the HMO plan.

Under the Choice of Providers provisions, the Bill requires that health plans give the patient the right to choose the primary care physicians and specialists within the plan. The plan can limit the number of specialists the patient can choose from, however. This provision is in reaction to plans that assign primary care physicians to a member as well as to plans under which a member may see a different physician each time he or she goes to a network clinic.

Under the Access to Specialty Care provisions of the Bill, women may select an obstetrician-gynecologist as a primary care physician. Women may also receive care from OB-GYNs without prior authorization if the care is routine or pregnancy-related. Also under these provisions, the Bill requires that health plans have a process in place to refer patients with serious or chronic conditions to specialists. If the appropriate specialist is not part of the plan's network, the plan must cover care from the specialist at no additional charge than if the specialist were in the network. Medicare provisions already grant special women's care rights.

Another provision under this section of the Bill is that the patient can select a specialist to coordinate the patient's care, if the patient has a serious condition. The patient may see the specialist without referral, and may use the specialist as their primary care physician. Also related to patients with serious conditions, the Bill requires that health plans have a *standing referral* process, so that patients who need to regularly see a specialist do not have to get a new referral every time they have an appointment with the specialist.

Under Section 105 of the Bill, Continuity of Care, if an employer discontinues one health plan for another, or if a provider within a plan is terminated without cause, patients who are undergoing a course of treatment with the provider from the former plan, or with the terminated provider, may continue receiving care from the provider for up to 90 days. If the patient is institutionalized, pregnant or terminally ill, the care may be received for a longer period of time. Under such a situation, the terminated provider or the former health plan must agree to accept the payment rates, policies and procedures of the current health plan for the continuing care provided. This provision

stems from criticism of plans that require a patient to change physicians in what may be a critical time in terms of either the patient's health or mental condition.

Under the Coverage for Individuals Participating in Approved Clinical Trials provisions of the Bill, health plans cannot deny coverage for routine costs to participate in specified clinical trials. In order to qualify under this provision the following conditions must be met:

- The individual must have a life-threatening or serious illness for which no standard treatment is effective.
- The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.
- The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.
- Either the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions listed above, or the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described above.

These provisions are designed to give the patient more freedom to choose treatments that may not yet be proven to the medical community at large, but that a terminally ill patient wants to try.

Under the Access to Needed Prescription Drugs provisions, if a health plan provides coverage for prescription drugs based on a formulary, which as discussed previously, is the set of criteria under which various prescription drugs may be used and when, the physicians and pharmacists in the plan must be allowed to be involved in the formulary. The criteria of the formulary must be disclosed and an exception process must be in place so that non-formulary treatment can be provided when necessary.

Under Section 108, Adequacy of Provider Network, the Bill requires that health plans have a sufficient number, distribution and variety of health care professionals that participate within the plan so that all services covered by the plan are available and accessible in a timely manner to all members of the plan. This is similar to legislation already in place under Medicare managed care plan rules.

Under the Nondiscrimination in Delivery of Health Services plans, no health plan may discriminate against any member based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment in the care provided to plan members. Most states have similar discrimination clauses as part of their insurance code, although the state codes do not generally include *sexual orientation* in their statutes.

Subtitle B of the Bill, Quality Assurance, includes several more requirements for health care plans. Under Section 111, Internal Quality Assurance Program, the Bill requires that health plans have an ongoing internal quality assurance program. The quality assurance program must meet the following requirements:

- **Administration.** The plan or issuer must have a separate identifiable unit with responsibility for administration of the program.
- **Written Plan.** The plan or issuer has a written plan for the program that is updated annually and that specifies at least the following:
 - (A) The activities to be conducted.
 - (B) The organizational structure.
 - (C) The duties of the medical director.
 - (D) Criteria and procedures for the assessment of quality.
- **Systematic Review.** The program must provide for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

- **Quality Criteria.** The program
 - (A) Must use criteria that are based on performance and patient outcomes where feasible and appropriate;
 - (B) Must include criteria that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate;
 - (C) Must include methods for informing covered individuals of the benefit of preventive care and what specific benefits with respect to preventive care are covered under the plan or coverage; and
 - (D) Must make available to the public a description of the criteria used.
- **System for reporting.** The program has procedures for reporting of possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.
- **Data analysis.** The program provides, using data that include the data collected under section 112, for an analysis of the plan's or issuer's performance on quality measures.
- **Drug utilization review.** The program provides for a drug utilization review program in accordance with section 114.

These requirements are more detailed than those found in Medicare rules. Many plans already have some sort of quality assurance program in place.

Under the collection of standardized data provisions of the bill, health plans must collect and report uniform quality data to the secretary of health and human services that includes:

- Aggregate utilization data;
- Data on the demographic characteristics of participants, beneficiaries, and enrollees;
- Data on disease-specific and age-specific mortality rates and (to the extent feasible) morbidity rates of such individuals;
- Data on satisfaction of such individuals, including data on voluntary disenrollment and grievances; and
- Data on quality indicators and health outcomes, including, to the extent feasible and appropriate, data on pediatric cases and on a gender-specific basis.

Under the Process for Selection of Providers provisions of the Bill, all health plans must have a written process for the selection of participating health care providers. The process must include setting minimum professional requirements. Plans cannot exclude a physician because the doctor has a high-risk patient base, nor based solely on the scope of the physician's license. The plan may not discriminate against physicians based on race, national origin, sex, age, religion, disability, or sexual orientation.

Under Section 114 of the Bill, health plans that provide coverage for prescription drugs must establish and maintain a program that encourages the appropriate use of prescription drugs. Plans must also take action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

Section 115 addresses the utilization review process. This section of the Bill is quite long and detailed, indicating that the utilization review process of current health plans is an area of concern to lawmakers.

Sec. 115. Standards For Utilization Review Activities.

(A) Compliance With Requirements.

(1) In General. A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) Use Of Outside Agents. Nothing in this section is to be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) Utilization Review Defined. For purposes of this section, the terms *utilization review* and *utilization review activities* mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(B) Written Policies And Criteria.

(1) Written Policies. A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) Use Of Written Criteria.

(A) In General. Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 111(b)(4)(B).

(B) Continuing Use Of Standards In Retrospective Review. If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) Conduct Of Program Activities.

(1) Administration By Health Care Professionals. A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions. In this subsection, the term *health care professional* means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(2) Use Of Qualified, Independent Personnel.

(A) In General. A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate training in the conduct of such activities under the program.

(B) Peer Review Of Sample Of Adverse Clinical Determinations. Such a program shall provide that clinical peers (as defined in section 191(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

(C) Prohibition Of Contingent Compensation Arrangements. Such a program shall not, with respect to utilization review activities, permit or provide compensation or any- thing of value to its employees, agents, or contractors in a manner that:

- (i) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or
- (ii) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

(D) Prohibition Of Conflicts. Such a program shall not permit a health care professional who provides health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) Accessibility Of Review. Such a program shall provide that appropriate personnel performing utilization review activities under the program are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) Limits On Frequency. Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(5) Limitation On Information Requests.

Under such a program, information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

(6) Review Of Preliminary Utilization Review Decision. Under such program a participant, beneficiary, or enrollee or any provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(D) Deadline For Determinations.

(1) Prior Authorization Services. Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than business days after the date of receipt of information that is reasonably necessary to make such determination.

(2) Continued Care. In the case of a utilization review activity involving authorization for continued or extended health care services for an individual, or additional services for an individual undergoing a course of continued treatment prescribed by a health care provider, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 1 business day after the date of receipt of information that is reasonably necessary to make such determination. Such notice shall include, with respect to continued or extended health care services, the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date, if any.

(3) Previously Provided Services. In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination.

(4) Reference To Special Rules For Emergency Services, Maintenance Care, And Poststabilization Care. For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 101, respectively.

(E) Notice Of Adverse Determinations.

(1) In General. Notice of an adverse determination under a utilization review program shall be provided in printed form and shall include—

(A) the reasons for the determination (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 132; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such determination.

(2) Specification Of Any Additional Information. Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the determination in order to make a decision on such an appeal.

Under Section 116, the Bill requires the establishment of a health care quality advisory board. This board would be independent of any private organization.

Under the next section of the Bill, Subtitle C, provisions regarding patient information are included. Under Section 121, health plan providers are required to supply the following information to patients:

- (1) **Service Area.** The service area of the plan or issuer.
- (2) **Benefits.** Benefits offered under the plan or coverage, including—
 - (A) Covered benefits;
 - (B) Cost sharing, such as deductibles, coinsurance, and co payment amounts;
 - (C) The extent to which benefits may be obtained from nonparticipating providers;
 - (D) The extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;
 - (E) Process for determining experimental coverage; and
 - (F) Use of a prescription drug formulary.
- (3) **Access.** A description of the following:
 - (A) The number, mix, and distribution of providers under the plan or coverage.
 - (B) Out-of-network coverage (if any) provided by the plan or coverage.
 - (C) Any point-of-service option.
 - (D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.
 - (E) The rights and procedures for obtaining referrals to participating and nonparticipating providers.
 - (F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.
 - (G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 103(b)(2).
 - (H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage.
- (4) **Out-Of-Area Coverage.** Out-of-area coverage provided by the plan or issuer.
- (5) **Emergency Coverage.** Coverage of emergency services, including—
 - (A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;
 - (B) the process and procedures of the plan or issuer for obtaining emergency services; and
 - (C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.
- (6) **Percentage Of Premiums Used For Benefits (Loss-Ratios).** In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage.
- (7) **Prior Authorization Rules.** Rules regarding prior authorization or other review requirements that could result in noncoverage or non-payment.
- (8) **Grievance And Appeals Procedures.** All appeal or grievance rights and procedures under the plan or coverage.
- (9) **Quality Assurance.** A summary description of the data on quality collected under section 112(a).

(10) **Summary Of Provider Financial Incentives.** A summary description of the information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

(11) **Information On Issuer.** Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(12) **Availability Of Information On Request.** Notice that the information described in subsection (c) is available upon request.

(c) **Information Made Available Upon Request.** The information described in this subsection is the following:

(1) **Utilization Review Activities.** A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 115, including under any drug formulary program under section 107.

(2) **Grievance And Appeals Information.**

Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) **Method Of Physician Compensation.**

An overall summary description as to the method of compensation of participating physicians, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

(4) **Specific Information On Credentials Of Participating Providers.** In the case of each participating provider, a description of the credentials of the provider.

(5) **Confidentiality Policies And Procedures.** A description of the policies and procedures established to carry out section 122.

(6) **Formulary Restrictions.** A description of the nature of any drug formula restrictions.

(7) **Participating Provider List.** A list of current participating health care providers.

(d) **Form Of Disclosure.**

(1) **Uniformity.** Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area.

(2) **Information Into Handbook.** Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from making the information under subsections (b) and (c) available to participants, beneficiaries, and enrollees through an enrollee handbook or similar publication.

(3) **Updating Participating Provider Information.** The information on participating health care providers described in subsection

(b)(3)(C) shall be updated within such reasonable period as determined appropriate by the Secretary. Nothing in this section shall prevent an issuer from changing or updating other information made available under this section.

(e) **Construction.** Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

Many plans already disclose many of the items required under this section of the Bill. Some states require disclosure of many of these items as well.

Under Section 122, Patient Confidentiality, the Bill requires health plans to establish procedures to safeguard the privacy of any individually identifiable enrollee information, to maintain records and information in a manner that is accurate and timely, and to assure timely access of individuals to such records and information.

Under the Health Plan Ombudsmen section of the Bill, grants are established for states to create and operate health insurance ombudsman programs. The duties of the ombudsmen include helping citizens select the appropriate health care plan and to assist patients who have grievances or are

dissatisfied with their health plans. Many states already have such Ombudsmen available to senior citizens, if not to all citizens.

Under Subtitle D of the Bill, grievance and appeals procedures are required. Under Section 131, each plan must have a system to provide for the presentation and resolution of grievances that are brought by plan members. The system must include a written explanation of the way the grievance process works and a process of documenting and tracking grievances and appeals received. The system must assure timely resolution of any grievance or appeal.

Under Section 132, Internal Appeals of Adverse Determination, a member must be able to place an appeal against a:

- Denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.
- Failure to provide coverage of emergency services or reimbursement of maintenance care or post-stabilization care under section 101.
- Failure to provide a choice of provider under section 103.
- Failure to provide qualified health care providers under section 103.
- Failure to provide access to specialty and other care under section 104.
- Failure to provide continuation of care under section 105.
- Failure to provide coverage of routine patient costs in connection with an approval clinical trial under section 106.
- Failure to provide access to needed drugs under section 107(a)(3) or 107(b).
- Discrimination in delivery of services in violation of section 109.
- An adverse determination under a utilization review program under section 115.
- The imposition of a limitation that is prohibited under section 151.

The internal appeal must include a review by a health care professional or professionals who have not been involved in the appealable decision. The appeal process must be completed within a specified period of time, and if an appeal is denied, the member must be provided the reasons for the denial in writing. The Bill also provides for an expedited appeal process under circumstances when an expedited process is necessary to avoid jeopardizing the life or health of the patient. These provisions are in response to criticisms that plans unfairly deny coverage, or delay responding to coverage claims, in order to save money.

Under Section 133, External Appeals of Adverse Determinations, if a case is not resolved under the internal process and is a case that involves a specified amount of money or the patient's life or health is in jeopardy, or if the plan did not comply with the internal appeal process timeframes, a patient has the right to make an external appeal. Each health plan must contract with an external appeal entity which meets the specifications of such an entity under the Bill. Among other requirements, an external appeal entity must be certified by the Secretary of Labor or by a state agency.

Under Subtitle E, Protecting the Doctor-Patient Relationship, the Bill addresses various aspects of the Doctor-Patient relationship. This part of the Bill attempts to deal with some of the issues related to the concern that physicians will place the objectives of the managed care organization above care for patients.

Under Section 141, Prohibition of Interference with Certain Medical Communications, the health plan cannot require a physician to not inform a patient about appropriate treatments because the treatments cost more than the plan would like to spend.

Under the Prohibition Against Transfer of Indemnification or Improper Incentive Arrangements, no health plan can transfer liability to a health provider related to activities, actions, or omissions of the

plan, issuer, or agent. The Bill also defines the parameters of financial incentive programs, using language consistent with current Medicare laws regarding this same issue.

Section 143, Additional Provider Participation Rules, establishes procedures the plan must follow regarding the participation of health care professionals. Among other requirements, the plan must give the health care professionals notice of the plan participation rules, provide written notice of participation decisions that are adverse to professionals; and provide a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

Under Section 144, Protection for Patient Advocacy, the Bill includes provisions to protect health care providers who act as an advocate on behalf of a patient from retaliation by the health plan. The plan cannot retaliate against a provider for disclosing information to a public regulatory agency, a private accreditation body, or appropriate management within the health plan regarding concerns the provider has about care, services, or conditions affecting a member or patient. The health plan is also prohibited from retaliating against any participant, beneficiary, or enrollee because they have appealed or filed a grievance against the plan.

Under Subtitle F of the Bill, provisions intended to promote good medical practice are included. Under Section 151, the Bill states that a group health plan may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

Two provisions within the Bill address health care for women. Under Section 152, Standard Relating to Benefits for Certain Breast Cancer Treatments, mandated minimum length of stay coverage requirements for mastectomies and certain lumpectomies are included. A physician and patient can agree on earlier release dates, but the plan must provide coverage for the minimum lengths of time stated in the Bill. Under Section 153, Standards Relating to Benefits For Reconstructive Breast Surgery, health plans that provide coverage for breast surgery related to a mastectomy must also provide coverage for prostheses or reconstructive breast surgery, as well as for lymphedema related to the surgery.

One of the most controversial sections of the Bill is Section 302, *Erisa Preemption Not To Apply To Certain Actions Involving Health Insurance Policyholders*. Under this Section, health plan members would be allowed to file suit against the managed care organization for wrongful death or personal injury if state laws are passed to allow such suits. Generally, the judicial system has ruled that managed care organizations are not responsible for the treatment provided to patients. Rather, it has generally been held that the treatment of patients is the responsibility of the health care provider. Currently, a patient may recover only the amount of premium paid to a health insurer or managed care organization if a suit for damages is filed.

This Bill is an excellent example of what issues we can expect those in the managed care and health insurance industry to grapple with over the next several years. Whether all or only a few of its provisions are signed into law, those responsible for running and constructing managed care programs will be highly influenced by the ideas behind each provision.

Society's Point of View

The attitudes of society today also affect the managed care environment today. For example, people today have relatively high expectations of health providers. Medicine can now cure or relieve the symptoms of so many diseases and illnesses that people expect physicians to be able to help them quickly and without error. Physicians are expected to prescribe the best treatment without fail. Along with this expectation is the increased tendency of the average person to sue. Health care providers of all types, from licensed practical nurses, to paramedics, to heart surgeons are subject to the threat of legal action for real or perceived errors or lack of judgment. One of the reasons put forth to allow patients to sue managed care organizations, besides the view that the managed care organizations are providing medical advice, is that physicians want managed care organizations to compete on the same legal playing field on which the physicians must. Some physicians argue that one reason managed care organizations can offer care at lower costs than an individual practitioner is because managed care organizations do not have the specter of lawsuits hanging over them, requiring them to charge higher fees to cover huge malpractice insurance premiums.

Another societal influence on managed care is the marketplace's emphasis on quality and not simply on price. Customers of all services today, regardless of the type of service, expect to be treated well and competently. They are not willing to trade low cost for reduced or poor service. Therefore, consumers are demanding higher quality care from managed care providers, just as they are from providers of other services.

Finally, the biggest influence on the managed care industry today is the disparity of ideas concerning what comprises reasonable and adequate health care and how our society should receive it. Are we best served by non-profit or for-profit organizations? Should the federal government be given more say or less say in our health care decisions? What about state government? Should employer-sponsored health care be abandoned and individuals take on the responsibility for their own health care planning? Should physicians run all health care organizations or can corporations be trusted to do so? Does everyone have the right to health care, or does everyone have the right to live their lives in a way that may lead some of them to neglect the purchase of health care coverage? Can greed or laziness be discouraged through the implementation of proper incentives? There are many answers given to these questions, each question carrying with it opponents and proponents on each side of each issue. As our society hashes out these issues, the managed care industry will respond and change based on our preferences and demands. The focus on these issues will continue to cause managed care organizations to examine their services, their procedures and their motivations. Until these issues are decided, we can expect changes and innovations in managed care plans to continue.

Glossary

Capitation: to number by the head. Capitation refers to the practice of paying for patient care based on the number of patients under the care of a physician.

COBRA: stands for the *Consolidated Omnibus Budget Reconciliation Act of 1985*, and includes requirements for group health plans regarding health care continuation.

Copayment: a small amount paid by patients in a managed care system for the services received.

Deductible: the amount an insured is required to pay before the insurer will pay for a benefit.

EPO: Exclusive Provider Organizations

Fee-For-Service Care: under this type of care, every time a physician provides a service, the physician is paid a fee.

Formulary: A formulary is a list of medications that are used to treat various conditions and is used by physicians within a plan as a guide for prescribing medication appropriate to a patient's condition.

Group Health Plan: under federal regulations, a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families.

IPA: Independent Practice Association.

Managed Care: any health delivery system that includes the utilization of a network of providers and a process of overseeing the types of care and services provided by the physicians and other parties supplying health care inside of the network.

Network: refers to the physicians, hospitals, clinics, group practices and other health care providers participating in the managed care plan.

Open Enrollment Period: a period of time in which a new member may enroll.

POS: Point of Service Plans, which are plans that allow for the use of both HMO and non-network providers.

PPO: a Preferred Provider Organization.

Preferred Provider: a health care provider chosen by the managed care network or managed care sponsor (such as an employer) to provide the health care services outlined in the managed care plan.

Primary-Care Physician: the physician that gives most of the care to a patient. A primary care physician is typically a family doctor, pediatrician or other non-specialist.

Referral: the method used by a primary-care physician to give permission to a patient within the managed care network to receive medical care not provided by the primary-care physician.

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