

From PLI's Course Handbook

Insurance Law 2005: Understanding the ABC's

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HEALTH INSURANCE 101

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I. INTRODUCTION

Health insurance provides people with protection against financial loss resulting from illness. The subject of health insurance is very complicated because the “insurer” may be either the government, a private health insurer or a self-funded entity. Each such insurer is highly regulated through a different regulatory scheme.

This program is a primer on health insurance, therefore, an exhaustive study of the subject is outside of the scope of today’s program. Instead, the program and this article will provide a brief history of health insurance, an overview of government sponsored insurance programs and the problem of the uninsured, and the Federal and State regulatory framework; including HIPAA and the Medicare Prescription Drug Improvement Modernization Act of 2003. It will conclude by focusing on types of insurance products including a discussion of managed care.

II. A BRIEF HISTORY OF HEALTH INSURANCE

The provision of health benefits became a popular, cost effective method to increase employee compensation as a direct result of a confluence of events. Labor unions which had been growing in strength since the 1920's led the fight to obtain health insurance for their workers. During World War II, wage controls limited employers’ ability to compete for scarce workers. Employers began increasing employee health benefits in lieu of increasing wages in order to make their job offers more attractive. The government supported the concept of health insurance by establishing favorable federal tax treatment for employers offering health insurance. The for-profit health insurance industry developed out of the employers’ need to provide health insurance benefits and the insurer’s desire to share the risk of the potential for high cost of such benefits.

The earliest formal health insurance was Blue Cross. It was established in the 1930s under the auspices of the American Hospital Association. Blue Shield was established in the 1940s under the auspices of the American Medical Association. Blue Cross and Blue Shield were created by these provider organizations to obtain prompt payment and first dollar reimbursement for their members in exchange for the provider’s agreement to accept discounted fees. Blue Cross and Blue Shield maintained a competitive edge over traditional insurance companies for many years. Their not- for-profit status, and discount network enabled them to offer benefits at a lower rate. The Federal government established Medicare in 1965.¹ The joint Federal/State program, Medicaid, was established in

1965.² In 1973 Congress passed the Health Management Organizations Act of 1973 (“HMO Act”)³ to encourage the growth of health maintenance organizations. The advent of managed care, and the related deregulation of hospital rates, in many states, allowed private insurance companies to compete aggressively against Blue Cross and Blue Shield in the 1980’s and 1990’s. By the early 1990’s an alphabet soup of organizations offering various types of health insurance products had developed to further the provision of lower cost health insurance. Beginning in the later 1990’s in an effort to retain a competitive position, Blue Cross and Blue Shield organizations, throughout the country, began to privatize

III. HOW ARE PEOPLE INSURED TODAY?

Today people may be “insured” by one of four categories of insurers; private industry, employer self funded, government subsidized and government funded insurers.

A. Private Industry Insurance

The private insurance industry is regulated by the Department of Insurance in each state. Private for-profit insurance companies sell two basic types of health insurance policies, group and individual. Group health insurance insures a group of people and their dependents. A group policy is most often purchased by an employer for its employees. The rates are either based on the employer’s group experience or on a more general type of group experience called the community rate. Individual insurance is purchased by the self-employed or otherwise uninsured for themselves and their families. An individual policy is the most expensive type of insurance because unlike a large group employer, the individual does not have sufficient market power to negotiate a discount; plus the insurer does not have a group of healthy people among which to spread the risk of loss of the individual sick insured.

B. ERISA Plans

Sometimes employees receive insurance organized pursuant to ERISA. ERISA is regulated by the Federal Labor Department. ERISA plans may be administered solely by an employer or jointly managed

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1. Health Insurance for the Aged and Disabled, 42 U.S.C. §1395 (2003).
 2. Grants to States for Medicaid Assistance Program, 42 U.S.C. §1396 (2003).
 3. Requirements of Health Maintenance Organizations 42 U.S.C. §300e (2003).

by representatives of a union and an employer. The employer plan or jointly managed welfare fund may purchase an insurance policy or it may design its own plan and pay for the medical services directly out of its own funds. In the latter case, it is “self funding” claims and is a self insured plan. See p. 17 for more details.

C. Government Subsidized Insurance

Historically, Blue Cross and Blue Shield plans (the “Blues”) although established by associations as discussed above, were not-for-profit health insurance plans supported and regulated by state government. Because the government required the Blues to maintain their premium at a lower rate and accept all enrollees, as a trade off for its not-for-profit status, the Blues were frequently treated by the insured as the insurance of last resort. However, recently the private insurance industry and others have been permitted to negotiate discounts to hospital rates like the Blues. As a result, the Blues have become unable to compete with the new more flexible managed care products developed by the private insurers. Consequently, during the 1990’s, the Blues began to privatize on a state by state basis. Because the Blues have enjoyed government subsidies and tax breaks over the years, they have been required, usually by the attorney general of the state in which they operate, to set aside a portion of the money they obtain via the conversion process. These monies are often used to establish a foundation. The mission of the foundation will vary from state to state but usually includes care for the un-insured or seeks to improve health care delivery in some other way. New York’s Blue Cross was permitted to privatize in 2002.⁴ There has been significant criticism regarding the allocation of the resources to be set aside for the improvement of health care delivery. The allocation is currently the subject of litigation. The Health Insurance Plan of New York, (“HIP”) is currently seeking permission of the New York State Insurance and Health Departments and the State Attorney General to privatize as well. Government subsidies for broad ranging insurance tax breaks is disappearing from the insurance scene. They are being replaced by initiatives for individuals that permit tax free health care savings account on a very limited basis.

4. N.Y. Ins. Law § 7317 (McKinney 2003).

D. Federal and State Sponsored Insurance

Medicare is a federally sponsored and regulated program which provides health insurance benefits to people over the age of 65 as well as younger individuals with a statutorily specified chronic illness. Medicare offers indemnity, health maintenance organization, preferred provider organization and point of service programs. It is funded by a combination of employee contributions and taxes. Hospital services are fully paid by Medicare. Beneficiaries must pay a monthly premium and co-pay for physician coverage which varies in dollar amount with the type of policy. Until recently Medicare did not cover prescription benefits. In December 2003, the Medicare Prescription Drug Improvement Modernization act of 2003 was enacted. The prescription drug benefit, which begins in 2006, is voluntary and beneficiaries will be required to pay a monthly premium after enrolling. Prior to implementation of the prescription drug program, a temporary prescription drug discount card program was established. A transitional assistance program for low-income persons enrolled in endorsed programs is available⁵.

Medicaid is jointly sponsored and regulated by federal and state government and provides health insurance for the poor. The federal government has created the basic Medicaid program and schedule of benefits. A state desiring to alter the standard Medicaid benefit package must seek a Medicaid waiver from the Federal government. Medicare and Medicaid are administered through the Centers for Medicare and Medicaid Services, a Federal agency of the Health and Human Services Department (“CMS”). In New York Medicaid is jointly administered through the Departments of Social Services and Health. Medicaid eligibility is state specific. In New York a family of four in the year 2004 is eligible if it has a net monthly income of \$967 annually and resources not exceeding \$5,800.⁶ There are also Medicaid programs that permit a slightly higher level of resources for certain categories of people, notably women with their young children.

In recent years, in an attempt to insure more than the most poor and to decrease the growing pool of uninsured, New York has sought and successfully obtained a Medicaid waiver in order to insure individuals, couples and families who are not Medicaid eligible but are unable to afford health insurance. To be eligible, the income of a family of four

5. <http://www.cms.hhs.gov/medicarerereform> (January 5, 2005).

6. N.Y. Soc. Serv. Law §366 (McKinney 2004).

in the year 2004 must not exceed \$28,275. In New York such program is called Family Health-Plus.⁷⁸

IV. WHO IS INSURED AND WHO IS NOT?

Unlike many industrialized nations, among them Canada, Germany and England, the United States does not maintain universal insurance for its citizens. Consequently, there is a vast pool of people who are uninsured. Currently the number is 45 million Americans were uninsured in 2003, an increase of 1.4 million Americans since 2002 and an increase from 15.2% to 15.6% of the population.⁹ The segment of the American population with employment based health coverage dropped from 70.1% in 1987 to 64.2% in 2002 and 63% in 2003.¹⁰ Employers are not required to provide health insurance. Many of the uninsured are people employed by small companies for whom an insurance premium is too costly. For example, an EBRI survey indicates that in 2001, only 28% of employees of companies with fewer than 10 employees¹¹ were insured. An analysis of the 2003 Census survey indicates that persons with a family head working in a firm with fewer than ten workers face a 31.8% probability of being uninsured as opposed to an 18.4% likelihood if the firm has between 25-99 workers or 1.7 percent if the firm has 1000 or more workers. In order to address this problem, local governments may sponsor health insurance joint purchasing programs. For example, New York has established a new level of insurance called "Healthy New York" which permits groups of employers, with two to fifty employees, to jointly purchase health insurance. Such joint purchase allows the employer group to negotiate a lower premium from the insurer. Industries which have a high concentration of low paying jobs also tend to have a high concentration of uninsured because the cost of insurance is too high in proportion to the employee salary, the

7. Ibid.

8. Income, poverty and Health Insurance Coverage in the United States;: 2003, U.S. Census Bureau, U.S. Dept of Commerce (August 2004).

9. Politics and Policy, Congress Daily January 6, 2004, Lexis, Nexis Library, American Health Live File.

10. Paul Frunstin, *Uninsured Rose in 2003 as Number of Americans with Employment - Based Health Benefits Declined*, 253 EBRI Notes 2-3 (2004)

Sources of Health Insurance and Characteristics of the Uninsured. Analyses of the March 2003 Current Population Survey, 262 (2003 available at www.ebri.org/pbex/ibz64.htm).

11. Paul Frunstin, EBRI, and Ruth Helman, Matthew Greenwald and Associates *Small Employers and Health Benefits Finding Frontier 2002*; Smell Employer Health Benefit Survey, 253 EBRI Issue Brief (2003).

employer is unwilling to pay the full premium and the employee cannot afford to contribute. These uninsured are the working poor, not destitute enough to be eligible for Medicaid or Family Health-Plus but too poor to pay for health insurance. Overall the largest age group of uninsured is young adults between the ages of 18 and 24.

V. WHICH FEDERAL LAWS APPLY TO HEALTH INSURANCE?

There are a myriad of federal laws that apply to all health insurance policies. Below is a brief summary of the most important ones.

The Pregnancy Discrimination Act (“PDA”).¹² The PDA requires that an employer treat a disability or medical condition resulting from pregnancy or childbirth in the same manner as other disabilities or medical conditions are treated. For example, all benefits offered by an employer including health insurance, disability insurance, salary continuation, sick leave, and employment policies such as seniority, leave extension and reinstatement must be applied to people with a pregnancy related disability in the same way as they are applied to people with other medical disabilities.

The Age Discrimination in Employment Act (“ADEA”).¹³ The ADEA prohibits discrimination against employees 40 years and older who are employed by employers with twenty or more employees. The same health benefits must be offered to all employees. Generally speaking, an employer is required to maintain its health insurance plan as primary even if the employee is Medicare eligible.

The Health Management Organization Act of 1973 (the “HMO Act”).¹⁴ The HMO Act requires that an employer offering health insurance must include a health maintenance organization as part of its insurance program. The law was written to encourage the use of health maintenance organizations.

The Americans with Disabilities Act (“ADA”).¹⁵ The ADA prohibits discrimination against persons with disabilities and applies to employers with fifteen or more employees. Such employers are prohibited from treating individuals unequally in areas relating to hiring, firing, pay and promotion. In short, all employer benefits including health insurance must be provided to disabled and non-disabled employees alike. There is a

12. 42 U.S.C. §2000e(k) (2003).

13. Age Discrimination in Employment, 29 U.S.C. §621 (2003).

14. Requirements of Health Maintenance Organizations, 42 U.S.C. §300e (2003).

15. Equal Opportunity for Individuals with Disabilities 42 U.S.C. §12101 (2003).

caveat, the employer is only required to make a reasonable accommodation for the disabled employee and need not make such accommodation if it would cause the employer undue hardship. As you might imagine, a large body of law has developed around defining “reasonable accommodation” and “undue hardship.”

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).¹⁶ COBRA requires employers to permit their employees and such employee’s covered dependents, at their own discretion, to continue health insurance coverage for 18 months after their coverage would have been terminated as long as they pay the full cost of coverage. There are limited exceptions which allow for longer continuation periods.

The Omnibus Budget Reconciliation Act of 1993 (“OBRA”).¹⁷ OBRA seeks to protect out-of-wedlock children and children of divorce. It requires states to pass legislation prohibiting insurers from denying such children enrollment under a health plan. State law must also permit employers, in response to a court order, to withhold monies from an employee’s salary to pay for health insurance coverage for a child.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).¹⁸ HIPAA applies to both private industry group insurance and self-funded health plans. HIPAA is a huge complex law covering a wide range of topics. The sections that are pertinent to this discussion are the sections addressing the portability of health insurance and administrative simplification.

The section on portability of health insurance requires that health plans reduce any pre-existing condition exclusion period by the length of time a person had prior credible health insurance coverage, known as “credible coverage.” If there is no break in coverage, an insurer may not refuse to provide insurance coverage to a person with, a preexisting condition. The effect of this change is that people with existing medical conditions can now change their place of work without fear that they will lose their insurance. If there is a break in insurance coverage of longer than 63 days the person’s illness can be excluded from coverage. However, the pre-existing condition “look back” period is limited to twelve months. This means that the employee who does not have proof of credible coverage can be insured for everything except the pre-existing condition initially and once

16. Continuation coverage and additional standards for group health plans, 29 U.S.C. §1161 (2003).

17. 42 USC 1396g-1 (2003).

18. ERISA requirements, relating to portability, assessability and renewability 29 U.S.C. §1181 (2003).

the twelve month period passes the pre-existing condition must be insured as well. Employers must require their health plans to issue a certificate of credible coverage (proof of past insurance coverage) when an employee ceases being insured under the employer's plan.

The section on administrative simplification has caused the development of three sets of regulations; the electronic transaction regulations, the privacy regulations and the security regulations. Compliance with the Electronic Transactions and Code Set Standards was required by October 16, 2003. The regulation outlines industry-wide standards for the electronic exchange of health care data by covered entities (health care providers, health plans and health care clearinghouses). It establishes standard data content and formats for submission of electronic claims. It will require significant changes in the software used and therefore staff training as well.

Compliance with the Privacy Standards was required by covered entities by April 14, 2003. The privacy standards protect all personal health information (oral, written and electronic) that is created or held by covered entities. It enacts five new patient rights, including the right of patients to obtain a disclosure history and the requirement that covered entities obtain an authorization for release of protected health information for marketing and other special purposes.

Compliance with the Security Standards is required by April 2005. The Security Standards are the glue that holds the electronic transaction and privacy regulations together. After all, what is the point of carefully filing documents and then not locking the file drawer? The security regulations require, among other things:

- A Risk Analysis
- Policy and Procedure Manual
- Contingency Planning
- Internal Audit Mechanisms
- Employment Termination Procedures
- A Formal Certification of Completeness

The Mental Health Parity Act of 1996.¹⁹ This act prohibits employers with fifty or more employees from imposing annual or lifetime dollar limits on mental health and alcohol and substance abuse treatment services.

19. 42 U.S.C. §300gg-5 (2003).

The purpose of the act was to make mental health benefits available to the same degree as physical health benefits are available. In practice, as a result of the way the language was drafted, health plans have limited the number of mental health visits per year, thereby legally subverting the purpose of the law. Congress has attempted, without success, to pass a new, more tightly-drafted law.

The Newborns and Mother's Health Protection Act of 1996.²⁰This law requires that all health plans be designed to include payment for in-hospital coverage for at least 48 hours for a vaginally delivered newborn and 96 hours for a caesarian section delivered newborn.

Women's Health & Cancer Rights Act.²¹This act requires that health plans offering mastectomy services must also offer reconstructive breast surgery.

The Employee Retirement Insurance Security Act of 1974 ("ERISA").²²This complex law was primarily written to protect pension plans. However, it also covers welfare plans. Welfare plans are the plans that employers and sometimes employers and unions use to offer insured and self-insured health benefits to employees and their families. ERISA requires a plan to include seven elements:

- The plan must be established pursuant to a written document.
- The plan must be administered according to such document.
- The plan must be written in a way such that it is understandable to average employees.
- A copy of the summary plan description (SPD) must be given to each employee.
- The plan must describe the conditions that would cause forfeiture or denial of benefits.
- The plan document must indicate how the plan is funded.
- Annual financial reports must be submitted to the federal government and a summary annual report must be submitted to the participants.

For the most part, ERISA benefit plan self-insured payors are subject only to the Federal law, they are not subject to state regulation. Therefore

20. 42 U.S.C. §300gg-4 (2003).

21. 29 U.S.C. §1185b (2003).

22. 29 U.S.C. §1001 (2003).

aside from the Newborn and Mother Health Prevention Act 1996 and the Womens Health and Cancer Rights Act there are no mandatory rules regarding benefits and therefore the benefit plan can be quite creative in its design. In contrast, group and individual health insurance purchased through the private insurance industry is regulated by federal and state law. Therefore, in addition to the federal statutes, discussed above, insurance policy guidelines and the manner in which insurance companies do business are set by each State's department of insurance.

VI. HOW NEW YORK STATE INSURANCE LAWS REGULATE HEALTH INSURANCE

The New York State Insurance Department (the "Department") regulates the business of private health insurance in New York. All insurers either located in New York State, marketing insurance products or otherwise "doing business" in New York State must be licensed by the Department. The Superintendent of Insurance (the "Superintendent") leads the Department. He or she is an appointee of the Governor. The responsibilities of the Department include:

- Licensing insurance companies and insurance agents.
- Issuing regulations.
- Conducting market conduct examinations.
- Making legislative proposals.
- Monitoring and setting insurance premium rates, surcharges and tax rates.
- Handling complaints.
- Adopting model bills.
- Approving all insurance contracts prior to their being marketed.

The content and form of individual and group health insurance policies is dictated by New York State statute and regulation and enforced by the Department.²³ The administrative and benefit provisions are delineated in detail. For example, on the administrative side, all insurance contracts

23. Statutory mandatory administrative and benefit provisions appear in N.Y. Ins. Law §§ 3216 and 3217 (McKinney 2004) and N.Y. Ins. Law § 3221 (2003). The accompanying regulations appear at 11 N.Y. Comp. Codes Rules and Regs §52.1 et seq. (2003).

must include a definition of terms section, adhere to format and font requirements and notice requirements related to policy cancellation. In addition, there are specific requirements regarding when a policy can be altered, when groups or individuals become eligible for insurance, when premiums may become due, the conditions under which an insurer may decline to renew a policy, requirements regarding submitting a notice of claim to an insurer and limitations on how long after a notice of claim has been submitted is the insurer permitted to wait before it must pay the claim. There are regulations regarding the conversion of policies and other COBRA issues and finally there are rules that make it clear that it is not permissible for an insurer to issue a policy until the premium rates for such policy have been approved by the Superintendent.

In addition to administrative requirements, a comprehensive list of patient care coverage requirements known as mandatory benefits also appears in the New York statutes. “Mandatory Benefits” are defined as the benefits that are required to be offered under a group or individual policy. As discussed above, an employer is not obligated to offer health insurance at all, or in all areas, however, if a particular benefit is offered, the manner in which it is offered must be consistent with the requirements under the statute. Here is a list of the most common mandatory benefits. It is not intended to be all inclusive.

An insurer providing coverage for in-patient hospital care, known as major medical insurance, shall also include insurance coverage for:

- Pre-admission tests performed prior to scheduled surgery.
- Second surgical opinion by a qualified physician.
- Retention of mother and child 48 hours for vaginal birth and 72 hours for cesarean birth. This is New York’s version of the Pregnancy Discrimination Act.
- Direct access to primary and preventive obstetrical and gynecologic services for not less than two times per year.
- Mastectomy and reconstructive surgery services. New York’s version of the Women’s Health and Cancer Rights Act.
- Home care and nursing home care services must be a covered benefit if requested by policy holder.
- Treatment for alcoholism, substance abuse and chemical dependency if requested by the policy holder, New York’s Mental Health Parity Act.

- Hospice coverage - if requested by policy holder.
- If prescription drug coverage is provided, external medications must be included.
- Ambulatory Care in out-patient facilities and physicians offices - if requested by the policy holder.
- Coverage for emergency conditions.

The term “emergency condition” has been carefully defined by the legislature in response to insurer’s efforts to reduce the frequency of expensive, emergency room visits by unilaterally denying payment for such treatment. The definition states: “An emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms, of sufficient severity, including severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.”²⁴

Prior to implementation of this definition, if an individual experienced severe radiating chest pain which was ultimately determined, through diagnostic testing, to be indigestion rather than a heart attack, an insurer would deny payment on the grounds that the emergency room visit was not medically necessary. Legislation was enacted to prohibit this result.²⁵ As a matter of public policy, the legislature determined that it did not want New Yorkers to avoid emergency diagnostic treatment, with tragic results because they were afraid the service would not be covered by insurance.

VII. WHAT KIND OF HEALTH INSURANCE PLAN DESIGNS ARE AVAILABLE?

A. Indemnity

Currently, there is plenty of room for differentiation in how a health plan is designed. Until the 1990’s, an indemnity policy was the main

24. N.Y. Ins. Law §4900(c) (McKinney 2000).

25. N.Y. Ins. Law §4900(3) (McKinney 2000), N.Y. Pub. Health Law §4900 (McKinney 2002).

type of group health insurance available. Historically an employer would purchase the policy and pay the entire monthly premium for each employee. The employee and his dependents received treatment from any provider of their choice without paying any co-payment or deductible. The insurer paid out all insurance claims submitted to it by the provider on a fee-for-service basis. Medicare worked the same way.

The indemnity product does not include financial incentives for providers to deliver health care services efficiently because the provider gets paid each time he provides a service; the more services he provides, necessary or not, the more he is paid. In addition the fee-for-service methodology is relatively unpredictable for the insurer. Yearly costs are based on actuarial determinations which are subject to significant fluctuations. Such fluctuations make it more difficult to manage the cost of health insurance. As the cost of health insurance spiraled out of control, insurers and employers began to modify the structure of the standard indemnity policy to reduce the amount of services it covered and reduce or maintain the cost of the insurance premium.

Today, while indemnity plans still exist, it is rare to find one that has not been modified in one or more of the following manners:

- Requiring the insured to pay part of the insurance premium.
- Requiring the insured to pay co-insurance. Coinsurance is the portion of each insurance claim, that is the insured's responsibility, usually such portion is 20% of each claim.
- Increasing the insured's co-insurance obligation to 30% of each claim.
- Increasing the insured's deductible. The deductible is the first dollar amount that the insured is required to pay before the insurer is obligated to pay.
- Establishing a per hospital admission deductible.
- Requiring each family member to satisfy an annual deductible rather than permitting one family member's paid annual deductible to carry over to another.
- Prohibiting expenses incurred in the last three months of the previous year to be carried over towards payment of the deductible of the next year.
- Changing the fee formula the insurer pays from "reasonable and customary" to a "schedule". A schedule requires payment of a

flat maximum dollar amount per procedure. A reasonable and customary fee is set based on geographic and local industry information per procedure. The result of this change is that insureds pay more because the fee schedule is frozen, the extra cost, if any, is strictly the responsibility of the patient.

- More recently, a trend towards the high deductible plans (“HDHPs”) has emerged. A HDHP is basically insurance for significant or catastrophic illness. In these plans, as the name implies, the out of pocket cost before first dollar coverage occurs is so high that most standard services including annual physicals are paid on an out of pocket basis by the insured. The HDHP is frequently partnered with a Health Savings Account in which an individual can, prior to becoming Medicare eligible, save money on a tax exempt basis, to pay for health costs. At this time the maximum amount of annual savings is \$2,250.00. The rules regarding use, and investment of these monies is quite complex and is beyond the scope of this presentation.

Despite all of these attempts at reform, health insurance costs have not come under control. The reasons often given for this failure are:

- Health insurers failed to review claims, they did little to root out fraud;
- Insureds failed to control their utilization because they were not responsible for payment of benefits; and
- Sometimes physicians overtest or overtreat either in a futile effort to save patients or to avoid being accused of misdiagnosis or undertreatment.
- Simultaneous to the insurance policy reform, the notion of managed care evolved as a reaction to the increasing costs.

B. Managed Care

The goal of managed care is to limit the services rendered by the provider in order to save money for the insurer and the payor (plan purchaser/sponsor and the patient). Managed care can be defined as the interlocking processes of quality assurance, utilization review and financial incentives through which someone in addition to the health care provider or patient influences the medical care provided to a patient in order to control cost. In contrast to the indemnity plan fee-for-service payment methodology, managed care organizations

(“MCO”) pay a discounted renegotiated fee to the provider. The MCO may limit a patient’s access to providers by contracting to pay only if the provider is part of the MCO’s provider panel and has agreed to a discounted rate. The two most prevalent forms of MCO are the health maintenance organization (“HMO”) and the preferred provider organization (“PPO”).

Medicare and Medicaid offer managed care products. These products are regulated by the federal and state government. A managed care product is basically run the same way irrespective of whether its sponsor is the government or the private insurance industry. In this article we discuss managed care products in the context of the private insurance industry.

1. Health Maintenance Organizations

New York State regulates health maintenance organizations (“HMOs”) quite strictly. HMOs are jointly regulated and licensed by the Departments of Health and Insurance. The health care services and treatment provided by an HMO are regulated by the Department of Health.²⁶ The Insurance Department regulates the HMO’s filing, plan design, accounting and financial reserve requirements.²⁷ The HMO provides comprehensive health care to a population, an employee group, for example, at a pre-determined price that is pre-paid directly to the HMO. If the monthly premium received from the policy holder is more than the cost of the services paid for by the HMO, the HMO profits. If the revenue received from the policy holder is less than the cost of care, the HMO experiences a loss. This concept is no different than how all insurance works however, using managed care, the HMO seeks to shift the odds in its favor.

In an HMO, patients are assigned to a primary care physician (“PCP”). The PCP is usually an internist. Such physician provides initial treatment and acts as a “gate keeper” to the rest of the network. This means that the patient must see the PCP prior to seeing a specialist in the HMO. A pure HMO will not reimburse a provider or patient if the provider is not part of the HMO network. In such case the patient will be personally responsible for the bill. When the patient see an in-network provider the patient’s out-of-pocket expenses are limited to a small co-payment, usually \$15 or \$20 per provider visit.

26. N.Y. Pub. Health Law §§4401 et seq. (McKinney 2004).

27. N.Y. Ins. Law §§12-13 (McKinney 2000).

a) Financial Incentives

Some HMOs pay a fixed monthly fee to PCPs and specialists to provide care to a fixed number of patients. This type of arrangement is known as capitation. While capitation fees reduce the insurer's costs, they can have a negative effect. If the fee is too low for the number of patients the physician is obligated to treat or if the number of patients with complex illnesses is higher than projected, the physician may lose money. This may cause the physician to cut corners or provide minimal services to the detriment of the patient. In some cases the problem has been aggravated because HMOs have provided financial bonuses to PCPs to reduce the number of specialist visits. In this scenario, the PCP may seek to wrongfully limit or deny specialist treatment in order to earn the bonus.

New York enacted regulations to, for the first time, regulate the risk sharing, including capitation agreements between HMOs and providers.²⁸ These regulations were enacted specifically to prevent problems that had arisen largely in other states because HMOs, were shifting a lot of their own financial risk, which the Department argued was insurance risk, to providers including hospitals and physician groups. Some such providers took on more risk than was fiscally responsible and became unable to provide the services for which the patients and employers had paid a premium. Until this new regulation was created the Department had no jurisdiction over these downstream risk takers.

b) HMO Models

An HMO's internal organization depends upon the manner in which the physicians are organized. Most physicians are organized into either a staff model HMO or a physician group model HMO. In a staff model HMO, the physicians are employees of the HMO, and work at an HMO facility. HIP was originally a staff model HMO. It had clinics all across the city staffed with physician employees it had credentialed, insured and paid a salary. HIP has now divested itself of its physician employees and has become a physician group model HMO.

A physician group model, as the name implies, contracts with physician groups. A physician group model HMO is less expen-

28. 11 NYCRR §101 (2003).

sive to operate because the HMO need not operate facilities, manage physician employees and pay malpractice insurance premiums. In the physician group model, physicians see patients in their own offices. The physicians contract with the HMO either as an individual or through their professional corporation (“PC”) or professional limited liability corporation (“PLLC”), or their independent practice association (“IPA”). An IPA is a group of doctors who have developed an integrated group for the purpose of contracting with HMOs.

As a result of problems arising from this rather rigid plan design, the gatekeeper process and abuses driven by capitation, certain modifications to the HMO statutes have been implemented.

In 1996 the Legislature, responding to reports of abuse by HMO’s, created the Managed Care Reform Act (the “Act”).²⁹ The Act established the obligation of insurers and HMOs to provide information to consumers regarding their internal administrative processes including authorization protocol, reimbursement methodology including the presence of capitation contracts, and financial work sharing agreements, grievance and consumer complaint protocol and access to experimental and investigational treatment policies.³⁰

Effective 1999 the law was amended to add an appeal process external to the HMO and the insurer in order to assure that patients received a fair hearing for their appeals of HMO or insurer decisions. According to the NYS Insurance Department’s surveys of such appeals, overall approximately 50% have been overturned.

Additionally, to address the abuses that arose related to the capitation fees and physician incentive methodology, the New York statute has been written to prohibit under-treatment.³¹ These limitations include:

- An insurer may not offer monetary or other incentives to a health practitioner to induce such practitioner to provide less service;

29. N.Y. Ins. Law §3217(a) (McKinney 2004), N.Y. Pub. Health Law §4408 (McKinney 2004).

30. Anne Maltz, Managed Care Reform Act, N.Y.L.J., December 12, 1996 at 1.

31. N.Y.S. Ins. Law §3221(k)(1)(8)(B) (2004).

- An insurer may not provide incentives, monetary or otherwise, to encourage an insured person to accept less service;
- An insurer may not penalize, reduce or limit the compensation of a health care practitioner who recommends care that may be expensive or refuses to restrict length of stay of a patient in-hospital.
- There are strict limitations on when an insurer may deny payment for experimental or investigational medical treatments.

2. Preferred Provider Organizations

The first preferred provider organization (“PPO”) was established around 1911. It developed out of negotiated fee arrangements used in connection with worker’s compensation laws in the states of Washington and Oregon. Modern PPOs emerged in the 1980s. A PPO is an organization that creates a network of health care providers, including but not limited to hospitals, doctors, chiropractors, podiatrists and nurse practitioners, who have agreed to accept a discounted fee as payment in full for the service to be rendered directly to the patient. Such providers are paid on a fee for service basis. The providers join the PPO because although they are agreeing to accept a lower fee, they believe they will obtain a greater volume of patients which will more than make up for the discounted rate they are accepting. Providers are chosen by the PPO based on type of specialty, demographics and level of credentialing. Once the PPO has created its network its markets it to payors.

Unlike an HMO, in New York, a PPO is not regulated by either the Departments of Health or Insurance. However, since New York does regulate insurance companies, when an insurer offers a PPO as part of an insurance product, the PPO may be assessed by the Department. Because a PPO is a network and not an insured product it must either market itself to self-insured benefit funds or insurers. If a self-insured fund offers the PPO to its members, the members and fund immediately benefit from the PPO’s discounted rates. When a PPO is marketed by an insurer it is packaged as part of an insured product as another insurance option. Frequently PPOs will perform additional services like claims processing or utilization review for its clients.

As part of the movement away from managed care, health insurers and self-insured plans have begun offering two and three tier

health insurance products. An HMO is offered as the least expensive and most restrictive plan combined with a PPOs less restrictive and more expensive alternative. In some cases, a point of service plan is added as a third tier.

3. Point of Service Plans

A point of service (“POS”) plan provides the additional option to the patient of using an indemnity type fee-for-service plan. The POS plan gives the patient freedom to choose the provider without having to see a PCP or stay within the PPO network. Any referral by the POS provider is treated as an indemnity claim which greatly increases the cost of coverage to the patient. The POS plan gives a patient increased flexibility which the employee pays for with a higher deductible and co-payment. POS plans are costlier to the payor as well because the costs are again unpredictable and rise rapidly.

VIII. WHAT IS UTILIZATION MANAGEMENT?

Utilization Management is the management of how health care services are provided and used by the application of vigorous utilization review techniques. Originally developed to monitor and control the number of procedures and services used by patients in managed care plans, now its elements may be found in most insurance products.

Utilization Management is the system of evaluating the necessity, appropriateness and cost of the health care provided. Utilization Management occurs through the utilization review process. Utilization review is carefully regulated in New York State. Specific standards have been set for utilization review agents.³² The same standards are incorporated into the HMO statute for HMO utilization review functions.³³ It is the pre review, concurrent or retrospective review of the medical treatment of patients. An example of pre review is the requirement that surgery be pre-certified by the managed care organization (“MCO”) or utilization review agent. Concurrent review is where the MCO or utilization review agent make recommendations regarding whether a medical treatment contemporaneously being received should continue to be rendered, for example, continuation of physical therapy or continuation of an in-hospital stay. Retrospective review is where the MCO or utilization review agent deter-

32. N.Y. Pub. Health Law § 4900 (McKinney 2004).

33. N.Y. Ins. Law § 4900 (McKinney 2004).

mines whether treatment/services previously rendered service should have been rendered.

Once a decision is made that treatment is not medically necessary, or not otherwise appropriate, a decision which is contrary to the provider's opinion, such decision becomes known as an "adverse determination." An adverse determination means that the MCO will not pay for the service. Often this means the treatment cannot proceed because the patient cannot afford the treatment without insurance. Sometimes the patient will pay for the treatment while they are appealing the adverse determination.

Utilization review decisions are based on three concepts:

- Whether the treatment is medically necessary and appropriate. This includes a review of the frequency and duration of the care.
- Whether a lower cost form of care is available and is arguably more appropriate.
- Whether the patient improved as a result of the treatment.

IX. WHAT IS QUALITY ASSURANCE?

Managed care is designed to control the cost of health care. As we've seen, the controls also create the danger of decreasing the quality of care, and under-treatment. It is important for providers and employers to make certain they are neither part of the problem nor a victim of the problem. The purpose of quality assurance is to support a high quality of care by setting credentialed standards and measuring treatment outcomes and patient satisfaction. It requires the collection of data on utilization of services, cost and quality. The data is integrated into a format that is standardized and readable. The process is initially expensive to implement because it requires complex software, increased administrative costs and staff and provider education.

Initial quality assurance efforts were focused on tracking the practice patterns of providers, i.e. the frequency with which certain tests and services are provided. The purpose was to examine patterns of delivery of care that exceeded the norm. Such providers were subject to more intense review. More recent quality assurance efforts have centered around the establishment of clinical outcome indices. These are standards for the provision of treatment for a particular medical condition or disease.

The theory behind this movement known as "quality management", is that if a standard can be set that is, in general, the best treatment for a particular condition, and if physicians will commit to providing at least this

baseline level of care, patients will stay healthier and costs to the insurer or health plan will be less and the decreased costs can be passed on to the payor and consumer. For example, diabetes is a life long disease, the cost of which can be limited if patients are properly monitored, treated and educated to manage themselves. If a baseline level of care is given to all patients, for example, yearly eye, and circulatory evaluations and periodic blood glucose check-ups, patient education and nutritional support, the costs related to treating uncontrolled diabetes will be reduced. Once practice standards are set providers are encouraged to use them by the health plan. Sometimes financial incentives may be added to encourage swifter compliance. Currently there are nationwide efforts underway to reduce in hospital medication errors and the associated death's and costs, through the use of computerized pharmaceutical records³⁴

The other aspect of quality assurance is credentialing. Credentialing is the periodic review of provider credentials to determine whether the provider is properly licensed and certified, and is in good standing with all federal and state agencies and employers. In recent years, the National Committee for Quality Assurance (“NCQA”), a non-profit organization based in Washington, has established credentialing standards for health plans that enable health care consumers to evaluate MCOs. NCQA’s certification standard helps to make health plans accountable for the quality of the services they provide. NCQA evaluates the MCOs internal quality controls and helps to create measures of health plan performance.

X. CONCLUSION

Health Insurance is a complex topic. It is important to approach each insurance question by asking:

- How is the entity insured?
- How is the insurance regulated?
- How is the insurance plan designed?

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US Department of Health & Human Services: www.dhhs.gov