

# Understanding Health Insurance Plan Models



One of the (many) things that separates the business of medicine from so many other industries is the complexity of healthcare reimbursement. The healthcare reform process in the United States is shining an unrelenting spotlight on the price variances between identical services and the inscrutable way that providers set their fees. Since a large portion of the services rendered are negotiated and paid for by a third party, medical managers deal with a different set of challenges and require a specialized understanding of how payment mechanisms operate.

As we are all patients, we can all benefit from a basic understanding of the most popular types of insurance plans, and how they work for subscribers. Understanding health insurance is critical to understanding medical management as well as how healthcare is changing under reform.

## **Indemnity plans (often called 80/20 plans)**

These plans typically have a deductible – the amount the patient pays before the insurance company begins paying benefits. After the patient's covered expenses exceed the deductible amount, benefits are paid as a percentage of actual provider charges, often 80 percent. These plans usually

provide the most flexibility in choosing where and from whom to get healthcare.

## **Preferred Provider Organization (PPO) plans (also called a network plan)**

In these plans the insurance company enters into contracts with selected hospitals and physicians to furnish services at a discounted rate. Patients may see a provider within the network without a referral. Patients with this plan may be able to seek care from a doctor or hospital that is not a preferred provider (considered “out-of-network” providers) but the patient will have to pay a higher deductible or co-payment. Exceptions exist if covered medical services are not available inside the network.

## **Exclusive Provider Organizations (EPOs)**

Very similar to HMOs, EPOs may limit coverage to providers inside their networks, however EPOs do not generally require referrals to see in-network specialists. EPOs are often the insurance plan of choice for self-insured hospitals and large medical systems.

## **Health Maintenance Organization (HMO) plans (also called gatekeeper plans)**

These plans have patients choose a primary care physician (PCP) from a list of HMO providers. The PCP is responsible for coordinating all healthcare for their HMO patients. If patients need care from any network provider other than the PCP, the PCP usually must provide a referral. Only care provided by a participating HMO provider will be paid. Treatment received outside the network is usually not covered, or is covered at a significantly reduced level. HMO plans often have the lowest premiums, deductibles and co-pays, but can be restrictive on when and where patients can get care.

## **Point of Service (POS) plans**

These plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require patients to select a primary care physician (PCP.) Like a PPO, patients can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost.

## **Catastrophic Health Insurance Plan**

A catastrophic health insurance plan covers essential health benefits but has a very high deductible. This means it provides a kind of “safety net” coverage in case patients have an accident or serious illness. Catastrophic plans usually do not provide coverage for services like prescription drugs or shots. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means patients must pay thousands of dollars out-of-pocket before full coverage kicks in.

Some patients are combining catastrophic health insurance plans with **Direct Primary Care (DPC)**, where for a monthly fee, a primary care physician provides office visits and some additional care such as lab tests and flu shots.

## **Consumer-Driven Health Plans (CDHP)**

CDHP describes a wide range of approaches to give patients more incentive to control the cost of either their health benefits or health care. Patients have greater freedom in spending health care dollars up to a designated amount, and they receive full coverage for in-network preventive care. In return, they assume significantly higher cost sharing expenses after having used up the designated amount.

## **Health Reimbursement Arrangement (HRA)**

Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

## **Health Savings Account (HSA)**

A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose Health Care Flexible Spending Account (HCFSA) or be dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury.

## **High Deductible Health Plan (HDHP)**

A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least \$1,250 for individual coverage or at least \$2,500 for family coverage. The annual out-of-pocket amount (including deductibles and co-payments) the enrollee pays cannot exceed \$6,250 for individual coverage or \$12,500 for family coverage. These dollar amounts are for 2013.

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