

**Medical Plans
2012**

Medical benefits are available in a number of different designs that impact access, utilization and costs. For fully-insured plans, medical benefits are listed in the 'schedule of benefits' of the health plan certificate. The benefits available under these plans are generally not negotiable; typically, an employer simply selects patient costs (e.g., co-payments, coinsurance) from a range provided by the health insuring corporation or life and health insurance company. For self-insured plans, medical benefits are detailed in the 'summary plan description' of the health plan certificate. The covered benefit schedule which can be offered by an employer is largely unconstrained. The schedule of benefits or summary plan description is typically composed of a number of different sections that provide an overview of covered benefits. Benefit categories might include all of the following: physician and office services, outpatient services, inpatient facility, preventative services, mental health and substance abuse.

To address health care needs in health plan financing, five medical health insurance designs are generally available in the marketplace: Base medical and major medical (Base), comprehensive major medical (CMM), preferred provider organization (PPO), point of service (POS), and health maintenance organizations (HMO). Taken together, these plan designs represent a type of continuum. From the first to last, these health plan designs decrease the freedom of individuals to choose their own providers, increase cost-sharing, and increase the active management of health plan participants' health care.

Early research found that health plan designs with greater cost sharing were associated with lower medical plan service utilization; generally, this reduction did not discriminate between effective and ineffective care. Distressingly, this reduction was also found in preventive services.¹ Recent research indicates that more restrictive health insurance plans are associated with lower levels of patient satisfaction and trust in physicians.² To some extent, the effects found were partially dependent upon plan design components.

Traditional Fee for Service Designs

Base medical and major medical plan

A base medical and major medical plan covers 100 percent of certain basic health care services such as hospital, surgical and physician services up to established limits. Thereafter, the major medical portion of the plan goes into effect for those items or for benefits not

¹ Newhouse, J. and the Insurance Experiment Group (1993). *Free for all? Lessons from the RAND health insurance experiment*. Cambridge, MA: Harvard University Press.

² Kemper, P., Tu, H.T., Reschovsky, J.D. & Schaefer, E. (2002). Insurance product design and its effects: Trade-offs along the managed care continuum. *Inquiry*, 39, 101-117.

covered under the base plan. Patients select providers freely and file claims with the health insurance carrier; covered patient expenses that are “usual, customary and reasonable” (UCR) are reimbursed. This means that the providers charge must be equivalent with what they normally charge and that the fee is within range of what most doctors in the area charge for that particular procedure given the same type of patient. These UCR rates are maximum limits set by the third party administrator or health insurance company; the amount actually paid is a function of the percentile of UCR that the administrator or company agrees to pay. These percentiles can differ greatly from company to company, and health insurance committees are encouraged to ask that the percentile be set at a particular level (e.g., 95th percentile).

Patient management strategies to reduce costs such as deductibles, co-insurance and co-payments typically apply only to the major medical portion of the plan. The plan does not attempt to manage costs through plan or provider strategies. These plans operate on an indemnity basis, meaning that the insurance contract covers individuals for covered losses within specific limits. Historically, these plans have been associated with higher claims costs than other plans.

Comprehensive major medical plan

A comprehensive major medical plan provides the same benefits as a base medical and major medical plan, but is characterized by deductibles and co-insurance provisions that attach to most covered benefits.

Like the base medical and major medical plan, the method used for setting the maximum allowed fee for each service has been historically based upon the usual charges by other physicians in the area, the customary charge by the particular doctor over the preceding year and “reasonable” adjustments for severity or special conditions. Plan advantages and disadvantages are similar to those arising under base medical and major medical plan designs. No constraint to provider choice exists and the patient is responsible for filing their own claims. These plans also operate on an indemnity basis, meaning that the insurance contract covers individuals for covered losses within specific limits. Historically, these plans have been associated with higher claims costs than other plans.

According to data collected annually by the Ohio State Employment Relations Board, less than 2% percent of all medical plans offered to Ohio school district and educational service center employees on January 1, 2012 were traditional plans (i.e., base medical and major medical plans or comprehensive major medical plans).

Managed Care Designs

Preferred provider organization plan

A preferred provider organization (PPO) plan is a contractual arrangement between independent or institutionally based providers and another entity (often an employer or insurance company) to deliver health services to a defined population at established fees.

The PPO contains a panel of physicians and health care institutions that constitute the preferred providers (“in-network” providers). Economic incentives encourage PPO members to use the in-network providers. Here, health care services are delivered on a fee-for-service basis at established rates, usually discounted from the physician's usual and customary rates. If a provider is in the network, they file claims directly with the insurer. If the provider is not in (‘outside’) the network, the patient files their own claims and is responsible for amounts over the established UCR levels. PPO plans are the most common plan design offered to public school employees. According to data collected annually by the Ohio State Employment Relations Board, 79 percent of all medical plans offered to Ohio school district and educational service center employees on January 1, 2012 were preferred provider organization plans.

Point of service plan

In a point of service (POS) plan, the enrollee has the choice of using a health care provider that is not part of the managed care plan's provider network at the point in time that service is rendered. Higher out-of-pocket costs are usually incurred than if the enrollee used a network provider. This type of plan design is fairly uncommon in the public school market. Under a POS plan, enrollees have incentives to use network providers. In comparison to PPO plan benefits, the degree of steerage (the coinsurance difference between in-network and non-network providers) is larger.

In these kinds of plans, health care is controlled by a plan participant's primary care physician (PCP). The number and geographic spread of PCPs and specialists are integral to the operation of the plan. As was the case in a PPO plan, the provider files claims with the insurer in-network and accepts a discounted fee while out of network, the patient files their own claims and is responsible for amounts over the established UCR levels. According to data collected annually by the Ohio State Employment Relations Board, 2 percent of all medical plans offered to Ohio school district and educational service center employees on January 1, 2012 were point of service plans.

Health maintenance organization plan

A health maintenance organization (HMO) is a prepaid health care plan that provides or arranges comprehensive health services for its enrolled members. HMOs may be organized

differently as represented by the following four models (or a combination): Group, IPA, network or staff.

Group - HMO that contracts with one or more independent group practices that exclusively provide health services to HMO patients.

IPA - HMO that contracts directly with physicians in independent practice or with one or more associations of physicians in independent practice.

Network - HMO that contracts with two or more independent group practices that provide health services to HMO patients and patients covered by other payers.

Staff - HMO that delivers health services through a salaried physician group that is employed by the HMO unit.

HMOs represent the most restrictive type of managed care plan that is widely available. HMOs are characterized by payments for a defined set of health care services for a defined population. By definition, health care sought outside of the established network is not reimbursed. According to data collected annually by the Ohio State Employment Relations Board, fewer than 4 percent of all medical plans offered to Ohio school district and educational service center employees on January 1, 2012 were health maintenance organization plans.

High deductible health plans

While not strictly a form of medical health insurance plan design, one other health insurance vehicles have been observed in the Ohio public sector health insurance market: health savings accounts coupled with a high deductible health plan. Briefly, a health savings account (HSA) is a tax-exempt trust or custodial account for the payment of qualified medical expenses. Eligibility is restricted to those persons who are enrolled in a high-deductible health plan (HDHP) that meets IRS requirements, are not covered by another health plan that is not a HDHP (with certain exceptions), are not enrolled in Medicare; and not eligible to be claimed as a dependent on another person's tax return. Ineligibility is not triggered through coverage for accidents, disability, dental, vision or long-term care.

In 2012, an HDHP is a health insurance plan in which the annual deductible for a single contract is at least \$1,200 and out-of-pocket expenses do not exceed \$6,050. For a family contract, the annual deductible must be at least \$2,400 with out-of-pocket expenses not in excess of \$12,100; by law, patient cost-sharing is indexed to inflation. For HDHP that feature a network, contribution limits are determined by the in-network deductible; deductibles and out-of-pocket fees are indexed for inflation and are guaranteed to increase in the future. For a family contract, no amounts can be payable from the plan until the family has incurred annual covered medical expenses in excess of the minimum annual deductible. Preventive care can be

covered at 100% of eligible expenses, but except for such expenses, the plan cannot provide benefits until the deductible is met. An HDHP can be fully- or self-insured by an employer.

According to data collected annually by the Ohio State Employment Relations Board, 14% of all medical plans offered to Ohio school district and educational service center employees on January 1, 2012 were high deductible health plans with a health savings account (as compared to 10% in 2011). Questions and comments regarding this report should be directed to OEA Research.

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