

**The US Managed Care / Health Insurance Industry:
A Fact Sheet & Glossary of Terms (2007)**

A “managed care” plan can be defined as an integrated system that manages health care services for an enrolled population rather than simply providing or paying for them. Services within managed care plans are usually delivered by providers who are under contract to, or employed by the plan.

Managed care plans use a variety of approaches to “manage” care, including:

- **Care management** (or utilization management) (CM/UM) tools such as hospital pre-certification, practice performance profiling and disease management (DM);
- Non-traditional provider targeted **financial arrangements** such as capitation, risk-sharing, incentive-based payments, or consumer targeted financial arrangements such as “consumer directed” accounts (see CDHP below);
- Non-traditional provider **organizational/delivery arrangements** such as mandated primary care gatekeepers, "closed" or “preferred” provider networks and consumer defined networks (see CDHP below)

No two managed care organizations (MCOs) are exactly alike and there is only limited consensus regarding nomenclature and taxonomies. The matter is confused even further by the rapid evolution and hybridization of existing plans.

Nonetheless, the common categories and variants of MCOs include:

- 1) **MANAGED INDEMNITY PLANS** -- Traditional FFS (fee-for-service) indemnity insurance plans making use of UM cost controls. (Note – if the doctor is not required to have his/her patient’s non-emergency hospitalization - or major surgical procedure - “pre-certified” by the plan, this plan is usually considered to be a traditional indemnity health plan without care management.)
- 2) **PREFERRED PROVIDER ORGANIZATIONS (PPOs)** -- Plans offering incentives for enrollees to use discounted networks of fee-for-service (FFS) providers. (A variant, an exclusive provider organization - EPO, mandates that enrollees stay within the provider network).
- 3) **CONSUMER “DRIVEN” (or “DEFINED” OR “DIRECTED”) HEALTH PLANS (CDHPs)** -- Many PPOs (and some managed indemnity plans and HMOs) are adding product lines within their plan that they term CDHPs. While there is not yet definitional consensus, in general, the main characteristic of a CDHP is a consumer managed fund of money (variably termed a medical -- or health -- spending -- or savings -- account (MSA, HSA). This fund is used to cover (usually up-front) medical costs before the health plan’s regular coverage kicks-in to pay bills. This MSA/HSA is usually managed via the web. Also, CDHPs usually involve web based targeted education or care management. In addition, sometimes once a year the “preferred” provider network is determined on a customized, self-directed basis by the consumer based on their willingness to pay a higher or lower premium for certain providers.
- 4) **INDIVIDUAL PRACTICE ASSOCIATION (IPA)/NETWORK MODEL HMOs**—A type of managed care health insurance plan that contracts with existing group and /or solo private practitioners to care for patients either on a capitated or risk-sharing FFS basis. Participating IPA physicians usually contract with more than one managed care plan. In this and other types of "pure HMOs", enrollees must stay within the network if they expect services to be covered. Note that sometimes a group of physicians that contracts with an IPA model HMO is also called an “IPA” even though it is not a health plan, per se.
- 5) **STAFF/GROUP MODEL HMOs**-- In a staff model HMO physicians are hired either directly by the HMO or by a separate physician group formed exclusively to serve that HMO's patients. In a group model plan (sometimes termed “pre-paid group practice” or PPGP plans), a large existing multi-specialty practice forms an exclusive relationship with one HMO. Doctors in staff/group model HMOs are paid mainly on a salary basis, though it is common for them to have financial incentives linked to productivity and efficiency.
- 6) **POINT OF SERVICE (POS) plans** -- A type of plan where the enrollee can decide at the "point of service" whether they want to stay within the HMO network or get services covered at less generous levels from providers "outside" the network. In a "triple option" plan enrollees choose from among IPA physicians,

PPO physicians, or non-network physicians. In an "open-ended HMO" (which can be considered a type of POS plan) enrollees choose between their HMO physician and providers from outside the network.

- 7) Physician Hospital Organizations (PHOs) -- a PHO is an umbrella corporate entity that is comprised of a physician group/network and one or more hospital(s). These organizations are often termed "Integrated Delivery Systems" (IDSs). (Though the term IDS is often also applied to Staff/Group HMOs as well, some of which also own hospitals.) Most PHOs are formed by hospitals as a way of ensuring their market share in an expanding managed care environment. The PHO can contract with one or more managed care plans to provide both physician and hospital services on either a FFS or capitated basis. Sometimes a PHO will get a "global risk" capitation payment from an HMO to cover virtually all services. Sometimes a PHO will undertake "direct contracting" with a large employer or a State government's Medicaid program. These direct contracted PHOs are sometimes called "Provider Sponsored Organizations" or PSOs. From the enrollee's perspective, the PSO or globally capitated PHO appears to be a self-contained MCO, not too different from an HMO.

The approximate market share of US managed care plans in 2007:

About 85% of insured Americans are in some type of managed care plan. (Remember about 15% of American have no insurance and are not included in this analysis.)

About 35% (of insured Americans) are in HMOs or POS plans

- 8% in staff/group model HMOs (non- POS)
- 19% in IPA/network HMOs (non-POS)
- 8% are in POS or "open-ended" HMOs (90% within IPA/networks)

About 45% are in PPOs or other systems where incentives or mandates are present to increase use of specific network providers.

The remainder of the managed care cohort (5%) are in some type of managed care indemnity plan or other type of non - HMO/PPO MCO such as a PSO.

It is estimated that less than 5% of insured American are currently in a type of insurance plan marketed as a Consumer Directed Health Plan (i.e., a CDHP). A CDHP can be housed within a PPO, HMO or so-called managed indemnity plan. As the new federal "MSA" law leads to increased tax incentives, this type of plan may grow.

A large proportion of the cohort of 15% of insured American that are not in managed care plans, are comprised of Medicare and Medicaid enrollees.

- About 65% of Medicaid recipients (including the State -- Children's Health Insurance Plans - S-CHIP) -- are in HMOs, PSOs, or some other form of Medicaid specific MCOs.
- About 15% of Medicare recipients are Medicare managed care plans, now termed "Medicare Advantage" plans. These consist mainly of "risk-contract" HMO plans (formerly termed "Medicare+Choice" plans). A small number (<5%) are enrolled in Medicare PPOs. The PPO number may grow as a result of the 2003 Medicare Modernization Act (MMA). Starting in 2006, a significant number of FFS Medicare enrollees (not in HMOs) enrolled in Prescription Drug Plans (PDPs) which are a type of private Pharmacy Benefit Management (PBM) insurance plan that offers beneficiaries the Medicare program's optional new "Part-D" drug coverage on an at-risk basis.

*Source: Dr. Jonathan P. Weiner
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