PART TWO

Medical and Other Health Benefits

In this part, the critically important topic of medical benefits and issues is explored. Of prime importance in any discussion of medical benefits is the subject of cost containment—a topic so important today that it is referred to, either explicitly or implicitly, in all the chapters in this section.

Part Two opens with a discussion of the basic designs and strategic consideration of health plans in Chapter 4. The next three chapters all deal in one way or another with recent ways of dealing with health care cost containment. Chapter 5 covers demand-side approaches to cost containment, Chapter 6 deals with managing and measuring care management intervention programs, and Chapter 7 examines consumer-driven health care plans. The focus of Chapter 8 is behavioral health care benefits, and Chapter 9 describes how to evaluate the quality of health care provided by plans—quality has tremendous impact on both treatment outcomes and plan costs.

The next four chapters expand the coverage of health benefits to four specific benefits. Chapter 10 discusses the problem of high prescription drug costs and plan designs found to curtail plan cost increases. Dental benefits, which are much valued by employees and require only a modest employer investment, are covered in Chapter 11. Long-term care insurance is the topic of Chapter 12. Finally, completing this series of chapters, Chapter 13 deals with disability income benefits.

CHAPTER 4

Health Plan Evolution

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Medical plans are an important benefit to the employees who receive them. In fact, several surveys[1] regarding the value that employees place on their respective employee benefit offerings universally rate health coverage as by far the most important benefit component to the majority of employees. This is particularly the case in more recent times as individuals have seen the cost of medical care significantly escalate, often outpacing the general level of price inflation for other goods and services. Even in times of relatively little inflation or in times of moderate deflation, the price of medical care seems to rise. Medical bills for those who do not have adequate health protection can mean depletion of family resources and ultimately financial ruin. Of those individuals and families whose financial circumstances have necessitated filing for bankruptcy, a significant number have identified health expenses and the loss of adequate medical coverage as a major contributing factor leading to the bankruptcy filing.[2]

Medical plans have changed considerably since first introduced as an employee benefit. While today's plans are considerably different from those offered in the past, we seem poised at the current time for yet another iterative step in the development of health plans. This impending

1. For instance, see Mercer Workplace Survey: 2010 results at www.mercer.com/articles/workplacesurvey 2010.
2. David U. Himmelstein, Elizabeth Warren, Deborah Thome and Steffie Woolhandler, "Illness and Injury as contributors to bankruptcy," *Health Affairs* (February 2005), pp. 1377–1387.

transformation of existing health plans is related to major health care reform legislation enacted in 2010 with passage of two laws: the Patient Protection and Affordable Health Care Act (PPACA), amended by the Health Care and Reconciliation Act of 2010. These combined laws make major revisions in the rules relating to employment-based plans. Beginning in 2014, these laws require that individuals obtain health coverage for themselves and their dependents. In preparing for mandated individual health coverage, major changes are occurring for insured and self-funded employer-based plans. Some of these preparatory changes commenced as early as plan years beginning after September 23, 2010.

THE EARLY ORIGINS OF MEDICAL PLANS

The early medical plans were either prepaid service plans providing a set allowance for hospitalization/medical services or traditional indemnity-type plans providing cash reimbursement for specific covered services. These approaches to medical insurance have become far less popular among employers in the present era because of the inability to manage costs and the failure to place a value on the health care received. Although traditional prepayment and indemnity designs may still be found on a very limited basis in employee benefit plans and as choices in some flexible benefit programs, medical care increasingly moved to managed care programs during the 1980s and 1990s. In more recent times, consumer-driven health plan designs have been added to the menu of health plan alternatives. Consumer driven health plan designs have not assumed a majority market share position in terms of plan participants seeking health coverage through the private health system. Managed care designs, inclusive of preferred provider organizations (PPOs), health maintenance organizations (HMOs), point-of-service (POS) programs, and consumer driven health plans (CDHPs), as a group predominate in the current landscape of private health plan offerings. These plans have replaced the traditional indemnity plans of yesteryear. However, even managed care plans and consumer driven health plan designs have faced significant rate increases and cost challenges. Employers continue to review their plan designs in search of better values.[3]

This chapter describes the early, traditional fee-for-service prepayment and indemnity plan structures and chronicles the evolving plan configurations that have led to today's predominant managed care programs. As alluded

3. Managed care plans and consumer driven health plans can involve a great variety of alternate designs.

to earlier, it appears these plans will again undergo significant transformation as the requirements of health care reform move from theory into practice. It is useful to understand that actual benefits and coverage levels varied widely among plans prior to the roll out of health reform. Since health reform established the concept of "minimum essential health coverage," it was likely that more standardization would occur in plan design. It is useful to have a rather comprehensive understanding of the benefits commonly provided through conventional plans. In the case of traditional indemnity programs, it is also helpful to understand which benefits were provided under the various component parts of the plan. The exact level of benefits was contractually defined by the insurer or plan sponsor, and the benefits described throughout this chapter are representative of benefits commonly provided. In addition to describing the evolutionary development of health plans and a preview of expected post health care reform plan features, the chapter also discusses issues in developing a health care strategy and describes common provider reimbursement approaches. Developing a health care strategy and determining the methodology for provider reimbursement are particularly important issues when the health care environment is in flux and as plan designs emerge from the actual implementation of legislated health care reforms. Other chapters in this *Handbook* cover in greater detail various types of managed care delivery systems, how to assess quality in health care, and specific approaches to controlling health care costs.

THE EVOLUTION OF HOSPITAL/MEDICAL PLAN DESIGNS

Hospital medical plans have evolved over the years.

Prepayment Service and Indemnity Plans

Because the primary distinction between original prepayment and insured indemnity products was whether the benefit coverages were stipulated as a set level of benefits or an indemnified dollar amount to cover a certain amount of benefit, these two types of plans are described together.

Hospitalization Coverage: The Early Days

Insurance that covered hospital stays was traditionally obtainable as a stand-alone product separate from insurance for medical services. Although medical benefit insurance has evolved into a more comprehensive product that covers hospital stays, physician services, and other medical expenses, it is still useful to examine the separate components.

The Blue Cross/Blue Shield organizations played a dominant role in the emergence of these early plans, setting up separate entities to handle hospital insurance and medical care insurance. Their hospital insurance products were configured as prepayment plans in which benefits were set in terms of allowable days of hospitalization. These plans emerged in the early 1930s. They contracted with hospitals and reimbursed them directly for patient lengths of stay. The Blue Cross organizations provided insurance to all policy seekers under their own charter. Insurance companies entered the marketplace soon thereafter but provided a hospital-day benefit that was based on a fixed dollar figure, which was the amount for which the insurance company indemnified the subscriber. This dollar figure was calculated based on the expected cost of the hospitalization. While the Blue Cross organizations were nonprofit entities, the insurance companies were for-profit organizations, were not community rated, and were not open to all those seeking coverage.

The early hospitalization plans were configured as first-dollar plans, in which benefits were paid from the first dollar of expense incurred, and the subscriber did not incur any expense with the hospitalization. This first-dollar coverage was in keeping with the model of a prepayment plan and was doable because the cost and utilization patterns for medical care were quite different from what they are today. Many of these plans, particularly the Blue Cross plans, were underwritten by community rating, an insurance approach whereby a uniform rate is used for all subscribers or insureds within a given geographical area.

Hospitalization Benefits: Further Development

The hospitalization portion of the pre-health-care-reform (2010) plans generally has covered all services, supplies, and procedures provided and billed through a hospital. These included the following:

- Inpatient room and board. This benefit usually covered hospital charges for a semiprivate room and board and other necessary services and supplies.
- Emergency care for services obtained at a hospital emergency room.
- Intensive and specialty care.
- Maternity and required associated newborn care for a set number of days or a stipulated dollar amount.

- X-ray, diagnostic testing, and laboratory expenses when the insured was hospital-confined or when these services were performed by a hospital on either an inpatient or outpatient basis.
- Skilled nursing facility care. A plan would pay for confinement in a skilled nursing facility if it met prescribed requirements. Usually, there was a daily limitation either on a yearly basis or per confinement. Historically, a hospital stay of at least three consecutive days immediately prior to confinement was required to trigger allowance for skilled nursing facility care. Many plans have eliminated this prior hospitalization requirement.
- Radiation and chemotherapy. This benefit typically covered materials and their preparation, as well as use of hospital facilities.
- Inpatient mental and nervous care.
- Inpatient drug and alcohol substance abuse care.
- Physical, inhalation, and cardiac therapy.
- Home health care. This benefit was provided for a specific number of visits per year by physicians, nurses, and home health aides. Care usually had to be under a treatment plan supervised by a home health agency.
- Hospice care. This benefit was provided when the subscriber's attending physician certified that the subscriber had a terminal illness with a limited medical prognosis, in many plans six months or less. This type of care allowed the subscriber to receive care primarily at home, to help relieve pain and provide comfort rather than curing the patient. Hospice care typically allowed for admission into a hospice facility, and benefits would usually be provided until the earlier of either a patient's death or discharge from a hospice.
- Respite care. Coupled with hospice care, this benefit allowed the terminal patient short-term inpatient care in a skilled nursing facility or member hospice when it was necessary to relieve primary caregivers in the patient's home. An example of this benefit might be an allowance of seven days every six months.

Under a major medical plan (described below) when allowances for hospitalization services were exceeded by a plan participant, the excess charges typically flowed to the major medical component of the plan where the plan reimbursed the participant after he or she paid the applicable deductible and coinsurance amounts.