Description of Health Plan Types

Indemnity Plan – (*MNHG does not have this type of plan*)
Medical indemnity plans are those that most people think of as traditional insurance. Indemnity plans in their original form covered only identified *losses*, which were the high cost medical events like hospitalization. As the plans evolved and as they competed with managed care plans, the coverage expanded to include more outpatient care and even prescription drugs. The emphasis of indemnity plans is on covering the costs of illness and not on promoting wellness or early detection of disease.

With indemnity plans usually the member can go to any licensed medical provider and may self-refer to specialists. The medical indemnity plan pays medical providers on a fee-for-service basis and usually does not have contracts with the providers.

HMO *(“**EPO**” when self-funded)*
An HMO is a managed care plan in which members must use participating providers (network providers) in order to receive coverage unless they have an emergency or urgent need for care as defined by the HMO/EPO. Each member is required to select a primary care physician (PCP) who coordinates all care for the member. If the member wants to see a specialist, he or she must get a referral from the PCP*.

HMOs have very comprehensive benefits including preventive care and prescription drug coverage. Members are covered in full for inpatient care and pay modest co-payments for outpatient services and prescription drugs.

When an employer is offering an HMO on a self-funded basis, it is referred to as an Exclusive Provider Organization (EPO) plan.

In response to escalating costs, some healthcare organizations have now developed HMO products with front-end deductibles and large co-payments.

Point of Service (POS) plan
A POS plan is a managed care plan, usually built on an HMO network of providers. It differs from an HMO in that it has an “opt out” feature. The member receives full HMO level of coverage when going to providers in the network and following the referral procedures. While receiving care in network the member must go through his or her PCP for referrals to specialists. However, if the member wants to go outside the network, he or she may do so without a referral. For non-emergency care received outside the provider network, the member must pay a front-end deductible before being eligible for coverage. After the deductible has been met, the out-of-network care is covered at 80% by the plan and the member pays 20% up to a specific annual member out-of-pocket maximum.

Preferred Provider Organization (PPO) plan
A PPO plan has a network of providers. When the member uses the network, most care that is covered by the plan is covered at 100% (outpatient care, ER visits, and Rx subject to member co-pays). The member does <u>not</u> need to designate a Primary Care Physician (PCP). The member does not need to get a PCP referral in order to see a specialist. Members may choose to go outside the network for care in which case the member will pay a front-end deductible and then out-of-network care will be paid for by the plan at 80% with the member paying 20% up to a specific annual member out-of-pocket maximum. In response to escalating costs some healthcare organizations now offer PPO products with front-end deductible on both in-network and out-of-network services.

See the next page for a table of managed care plan features.

COMPARISON OF TYPES OF MANAGED CARE PLANS

Feature	HMO/EPO	POS	PPO
Premium Cost	Least costly	Intermediate cost	Most costly of managed care plans, but less costly than traditional indemnity plans.
Managed care procedures	Most	Intermediate	Least
Provider Network	Must use exclusively except for emergency/urgent.	In-network level of benefits are comprehensive; Out-of-network covered at 80% after deductible has been met up to out-of-pocket maximum, then plan pays 100% out-of-network. Provider network is usually same network as the organization's HMO provider network	In-network level of benefits are comprehensive; Out-of-network covered at 80% after deductible has been met up to out-of-pocket maximum, then plan pays 100% out-of-network. Provider network may be different from the organization's HMO provider network.
Provider discounts	Best	Usually same as HMO discounts	Not as good as HMO and POS, but better than indemnity plans
Requirement for a PCP	Each member must select a PCP	Each member must select a PCP	No requirement to select a PCP
Getting to see specialists	Member must get referral from PCP	In-Network: Member must get referral from PCP; Non-Network: Member may self-refer to specialists	Member may self-refer both in-network and out-of-network.
Oversight for Quality	Reasonably high level of oversight by National Committee on Quality Assurance (NCQA). In MA, much scrutiny by Mass. Healthcare Purchaser Group (MHPG).	For in-network: come under NCQA review of the underlying HMO plan. Same true with MHPG review	Very little oversight for quality. URAC is the accrediting body. No MHPG review.