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Chapter 5: Navigating the complexities of modern health insurance plans, networks, and policies

5.1. Introduction to Health Insurance

Health insurance is a type of insurance coverage that pays for medical and surgical expenses incurred by the insured. It can also provide coverage for non-medical expenses such as lost wages or funeral expenses, which are related to an illness or injury. An employer may arrange the insurance plan for an employee benefit, as part of a collective bargaining agreement. Individuals may purchase insurance or a family may be covered by a family plan. Insurance plans typically include a premium, a deductible, copayments and coinsurance. Health insurance can cover a portion of the cost of prescription drugs or may cover them entirely. In addition to traditional health insurance plans provided by employers, new types of plans have been developed in the past two decades. Health insurance is an important benefit that helps cover the high costs of medical care. As the cost of medical care continues to increase, the value of health insurance increases. However, the costs associated with operating the insurance system have escalated, leading to criticism about the excessive costs associated with health insurance. Advocates of universal coverage argue that the inefficiencies associated with a market-based system represent a failure of the uninsured to receive adequate care. In contrast, free-market advocates see the excessive costs and the inadequacies of present insurance coverage as a lack of competitive forces in the system. In effect, their argument is that many people are uninsured because the cost of insurance coverage is too high and that improving the efficiency of the current system will lower the cost of health insurance (Aminabee, 2024; Belispayeva & Nassyrova, 2024; Boda & Immaneni, 2024).

We can think of an insurance policy as a second chance at purchasing the goods you need – that is, medical treatment – but at a lower relative cost. Protecting yourself from unexpected and high spending in conjunction with needing those goods is socially desirable. To that end, most insurance plans require you to pay some share of a medical expense, a "deductible", before your insurance takes over your bills, and a portion of the bill throughout any course of treatment, in order to keep your incentives aligned with

preserving your health. More formally, this requires insurance companies to charge you premium prices such that you are always indifferent between "using" the insurance by suffering a loss and "not using" the insurance by experiencing no loss (Koura et al., 2024; Li, 2024; Tariq, 2024).

Fig 5.1: Navigating the Complexities of Modern Health Insurance Plans

5.1.1. Background and Significance

Health insurance offers security and peace of mind that can bring invaluable relief in times of uncertainty. The financial burden of unexpected or chronic illness is a big consideration when making decisions about your health and your family's health. As with any high-stakes purchase, including the purchase of any form of insurance, a wide range of options is made available to you and your family, especially if a plan is provided by your employer. These options raise a number of questions: how should health insurance be organized and structured? Which plan is best for me and my family? What do these options mean? How did we get here? Understanding the arcane structure of modern health insurance, and its impact on real-life health, can be deeply confusing. The

anxiety this insurance creates can be heightened yet again by navigating the proposals for reform that reappear in political campaigns. In this chapter, we will outline what you should know about this important topic, including its history and significance before helping you gain a stronger understanding of the academic research that sheds light on many of the most common options your insurance will convey.

5.2. Understanding Health Insurance Plans

Health insurance plays a critical role in protecting both individual health and the economy as a whole, seen as both a large and sovereign spending entity. An individual without health insurance is paying for the full price of their healthcare at the time of service, which is nigh impossible to afford when facing a medical emergency or an extended illness. Since most people cannot afford to pay for expensive medical procedures if they are needed, most people need health insurance to protect themselves against the worst-case scenarios. The individual alone cannot dictate the terms of the overall healthcare market, as they will only pay for their own services as required. Therefore, health costs come from the entire society, and seeing how overall healthcare costs are a significant portion of the economy, it is in the interest of both private and public sectors to make sure most people have some kind of insurance.

Health insurance allows individuals to pay minimal amounts during expected medical visits since they are not bearing the entire cost of the operation. In this way, the insurance transferring company, be it a limited private group or the public government, accounts for some of the costs. These costs can include reassessing individual and group risk factors, but they are also lower overall when many patients are being grouped together, thus explaining why most people are covered by a community pool. The major plans that you will encounter in the United States include employer-based insurance, private insurance on the individual market, and public coverage through programs such as Medicaid and Medicare. Understanding the types of plans available, the features of different insurance products, and the specific terms of an insurance policy can help you make the right choices for yourself, your family, and your business, as well as help you navigate through the use of insurance while receiving medical care.

5.2.1. Types of Health Insurance Plans

Health insurance is one of the many types of insurance which aims at providing coverage for medical expenses incurred due to basic sickness, or any form of serious injury or bodily harm. These expenses may include diagnostic tests, medical treatments, medications, surgery, etc., that are undertaken by the insured person. Health insurance can be categorized into several types. The categorization is based on the basic rule/s on

how hospital bills are settled on your behalf, how the medical-related expenses will be received in case of hospitalization, and how you will choose your doctor. Generally, there are two major types of health insurance plans: Major Medical and Short-Term policies. These two can then be further subdivided into additional categories.

Major Medical Plans: These are plans which mainly cover medically necessary hospitalizations. Major medical plans have a high deductible, which is the portion of the bill you pay in full before announcements of billing in excess of that deductible. The limit for individual coverage under a major medical plan is usually between a specified range per period of coverage. However, family coverage limits are usually higher. Once you meet your deductible, you pay coinsurance, which is a percentage of the rest of the bill, the insurance company pays the remaining percentage until the bill reaches a predetermined maximum. Major medical plans are for those in good health; you do not anticipate a lot of doctor visits, and you believe that it is worth paying a higher deductible and coinsurance to have a lower premium.

5.2.2. Key Components of Health Insurance Plans

Health insurance encompasses innumerable plan components that are difficult for consumers to decipher. The following provides brief definitions for key components that affect out-of-pocket costs. Not every plan will have every component, and some components may be labeled differently. We provide this information to help clarify the meanings behind some of the insurance jargon that one may encounter.

Monthly premium: The fixed dollar amount that one pays to an insurance company on a monthly basis for a health plan. One pays this amount whether or not any services are used.

Deductible: The fixed dollar amount that one pays on covered services before the health insurance plan pays. For example, if a plan has a $1,000 deductible, the insurance company will not pay until the individual has spent $1,000 of their own money on services. Deductibles can be applied to all services or only to select services.

Co-payment: The fixed dollar amount that one pays for certain services. For example, if a plan has a $40 co-pay for primary care doctor visits, one pays $40, and the insurance company pays the rest.

Co-insurance: The percentage of the cost that one pays for certain services. For example, with a 20% co-insurance on outpatient surgery that costs $1,000, the individual pays $200 and the health plan pays $800. This usually applies once the deductible has been met.

Out-of-pocket maximum: The maximum amount that one spends on covered services within a year. Once this limit is met, the insurance company pays 100% of additional services.

Network: The group of doctors, hospitals, and other service providers who agree to provide services to the health plan at contracted rates. Generally, one pays less out of pocket if an in-network provider is used.

Essential health benefits: Coverage for problems that are mandated for all non-catastrophic health plans: outpatient, emergency, hospitalization, maternity, mental health, prescription drugs, and rehabilitative services.

5.3. Health Insurance Networks

Health insurance networks steer enrollees toward specific groups of providers and facilities in exchange for reduced out-of-pocket costs. If you choose to visit providers in your plan's network, you will pay the least for care; going outside of your network will generally result in the highest costs; and a small number of plans will not cover any of the expenses of outside care. Each network is made up of different types of providers, from primary care physicians to hospitals. Even the most circumscribed network of providers will not lack specialists or facilities for the majority of procedures, but patients being directed toward a less familiar or simply different doctor can create trouble when a specialized knowledge or relationship is relevant to the procedure being performed. Because provider quality in terms of outcomes can be legally and practically difficult for plans to assess, publicly available measures like cost, efficiency, utilization, and patient experience take precedence in the calculations that determine panel composition. Insurers tend to focus on patients' experience of outpatient visits with several aspects of primary care. Less frequent airing of grievances relating to the doing of surgery or passing of radiology tests is generally neglected.

Types of Provider Networks

There are three main types of insurance networks: Health Maintenance Organizations, Preferred Provider Organizations, and Exclusive Provider Organizations. Most other plans take these types as a basic model, tweaking the specifics of benefits, coverage, and services offered rather than redesigning the network from the ground up.

Impact of Networks on Care

Preferred Provider Organizations are the least restrictive of networks, although they still generate rules in structure and supervision. Their treasury maintains ties with a relatively large panel of providers, both because these ties implicitly claim to quality and because

initially accepting the PPO schedule creates rapid access to patient pools that will, barring patient backlash, continue to grow.

Service benefit plans are health benefits that companies provide for their employees as part of an employee benefits package. Coverage requirements are usually spelled out in an employee benefits summary document, some of which, in addition to describing covered services, specify how much of the cost of care the employee (or some other payer) should plan for, and how the employer will involve itself in payment for the remaining medically necessary portion. Health insurance coverage is most often viewed as third-party payer coverage, and is thought of as being provided by separately branded for-profit companies or government agencies.

Fig 5.2: Health Insurance Networks

5.3.1. Types of Provider Networks

Provider networks are usually grouped into types, based in large part on the structure of the payments that insurers and/or governments provide for services delivered by network

providers. Network types also differ with respect to the ease or difficulty of referrals to out-of-network specialty or hospital services, and with respect to the administrative cost of managing access to services. Traditionally, there were four broad types of provider networks, distinguished by how they paid the individual providers: indemnity plans, service benefit plans, managed care organizations, and systems.

Indemnity plans are insurance contracts that provide a promise of coverage for a share of the costs of medically necessary services. They do not review proposed services for "pre-authorization," do not usually require a medical provider to be on the plan's panel, and do not manage the medical care delivered to enrolled patients. The individual providers regiment care services using clinical practice guidelines, protocols, and pathways. Coverage requirements are usually detailed in a plan document, some of which, in addition to describing covered services and the basis of medical necessity, specify how much of the cost of care the patient (or some other payer) is responsible for, and how the plan will involve itself in payment of the remaining medically necessary portion.

5.3.2. Impact of Networks on Care

Inherent in the design of a network-based insurance product is an intent to encourage specific behaviors by providers and consumers — and a belief that influenced behaviors will optimize value. Traditional capitated insurance products reward providers for increasing efficiency, minimizing the use of care while improving quality. The result is lower costs and greater satisfaction by consumers and payers in instances of overprovisioning or no need for care. The insurance product encourages these behaviors because it financially rewards the provider. Increasing the benefits of networks is a way of enhancing the positive impact of networks upon healthcare economics.

Without networks, all providers receive the same reimbursement rates from the same payers — and each provider has the financial incentive to provide as much care as possible. This is what an economist would call a perverse incentive. A perverse incentive creates the possibility of overprovisioning, causing total system costs to rise above that which would be created by a healthcare system that was competitive and singularly focused on efficiency. In these instances, where care is excessive, a provider would experience greater income by delivering more care while reducing effort than if they only undertook the degree of effort that consumers viewed as necessary and appropriate. For those consumers with a direct financial interest in the costs of their care being minimized, the “reward” for shared savings would optimize the behavioral dynamics described. Creating a reward for increasing efficiency and quality at the same time creates a powerful hedge against the perverse incentive problem, directing behaviors so

that diminished incentives for overprovisioning while increasing quality at the same time could occur.

5.4. Policy Regulations and Compliance

Regulatory policy compliance in health insurance tends to be concerned with adherence to legislative and regulatory requirements pertaining to the facts, circumstances, and specific activities that may exist or occur throughout the health insurance process. This idea is easiest to understand by examining a short, simple healthcare service transaction. A consumer has a healthcare need and receives a healthcare service from a healthcare provider and receives the service bill. The healthcare provider submits the claim and the appropriate transaction-related documents to an insurance company, which processes the claim and pays the provider in accordance with the terms of the insurance policy. The consumer pays the bill to the provider and the company pays to the consumer. The consumer receives the processed claim documentation from the company. A straightforward contribution and benefit arrangement exists. What complicates this transaction is it is done by a business, a registered healthcare provider, as a customer service offer, on behalf and with the support of a business – registered insurance company. The company earns a profit by charging a fee, called a premium, and agrees through a contract called an insurance policy to absorb the financial cost of certain unfortunate events that occur on behalf of the consumer.

While the transactional principle may at first seem clear and simple, it is not. A multitude of additional variables and factors related to the health insurance process exist or occur. The healthcare provider and insurance company are not actually providing the service and bearing the cost. They are providing a customer service function for their actual principal customers, the consumer and his or her dependent family members. The service and cost bearing function involves financial transactions between the customer and the businesses, the healthcare provider and the insurance company, as well as the consumer. Each of these transactions, as well as the insurance policy and plan they are relying upon, is subject to a multitude of conditional regulatory requirements. Such transactions exist between both of these parties, as both are doing things to each other and for each other at the same time. There are also additional parties or entities – state and federal governments operating through their respective healthcare policies – that have a vested interest in these consumer-business financial transactions.

5.4.1. Federal Regulations

The federal government has enacted three major statutes that serve as a basis for modern policies governing general health plan compliance and coverage: the Employee

Retirement Income Security Act, the Consolidated Omnibus Budget Reconciliation Act, and the Health Insurance Portability and Accountability Act. Each governs a different aspect of compliance and policy, creating a framework for other, more specific laws regarding particular diseases, individuals, or situations.

The first federal statute that is concerned with health insurance is the Employee Retirement Income Security Act. This act was passed in 1974 and was created to regularize and protect employer-sponsored retirement and pension plans. A consequence of its construction is that all employer-sponsored health plans, as well as employer payment plans, are also covered. Currently, large employer-sponsored group and multiple-employer plans, along with single-employer group health plans, are governed by Title I of this act, which is designed to protect employees and their health benefits by regulating the relationship between employees and their employers. This act preempts any state law from affecting the employer-employee relationship, and any violation of Title I results in a lawsuit being brought against the plan sponsor, further protecting employee benefits. Additionally, the statute is enforced by the Employee Benefits Security Administration, notifying interested plan participants or beneficiaries to check on any disparities between the statute and the plan language.

5.4.2. State Regulations

State laws and regulations govern every health insurance policy. State laws regulate not only the business but also the content of every policy of health insurance. Every health insurance policy is an agreement between the insurer and the insured. As in every other contract, the terms of the contract are set out in the policy. Each state has a department or bureau to oversee health insurance and the insurers that issue policies in that state. These services are parts of the insurance regulatory system in the United States. In each state, the duties of the insurance regulators are generally the same, even though the degree of strength, power, and force varies from state to state. The basic goals of the regulation of the business of insurance in the states are to protect the public: to maintain fair and orderly markets, to promote availability of insurance coverage, and to ensure the financial stability of the insurance transactions. Since every health insurance policy is a contract, there must be a means for enforcing the contract. Insurance regulators oversee and enforce the business and content of the health insurance policy contract.

Almost every health insurance policy is issued by an insurer located in a particular state. That state makes the policy possible by granting (or renewing) the insurer's license to do business. Health insurance policy regulations are necessary because of the highly technical nature of contractual language of the policy. Since the policy is written to protect the insurer primarily, the regulations attempt to address concerns of the consumers. The terms of each policy can differ significantly. State regulation applies to

insurance regardless of the source of the insurance funds. Thus state law can regulate the benefit levels and financial management of an HMO health insurance policy, but not Medicare and Medicaid. In addition to the HMOs, some additional insurance products offered by managed care organizations are subject to state regulation as insurance policies.

5.5. Conclusion

Navigating the Complexities of Modern Health Insurance Plans, Networks, and Policies is not an easy task. The healthcare market is continually shifting and evolving. Insurance companies fluctuate premiums and deductibles. Employers alter their benefit plans year after year based on their cost vs. coverage considerations. Hospitals are bought and sold, merged or closed due to negotiation in fee schedule reimbursements with third-party payers. And even individuality within the patient population is a driving force toward change. Increasingly, patients have expressed their wishes for individualized care. The demand for high-quality service from their healthcare providers and affordable costs for access and utilization of all available services has become paramount.

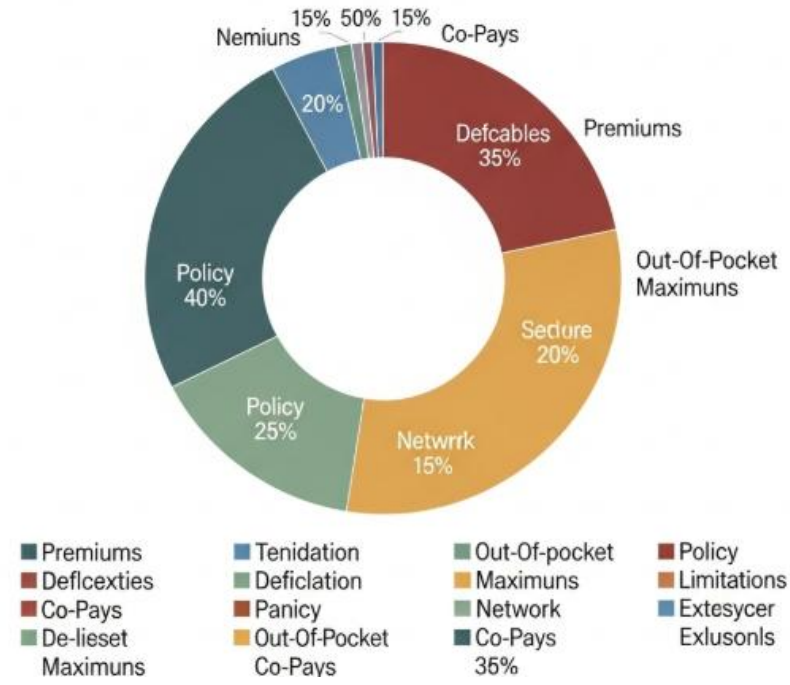

Fig : Navigating the Complexities of Modern Health Insurance Plans, Networks, and Policies

In part, this is the trend of "Consumerism," as patients act more and more like "consumers" of medical services. Industry surveys indicate that patients are increasingly seeking value in their healthcare decisions. They're more willing to switch healthcare providers and practices to get a better value or experience. And they're using digital tools to help facilitate access to their healthcare providers and services. But there is also a cultural transition toward readily available alternative methods of care delivery. The demand for high-quality patient-centered care has directly influenced the emergence of "Direct Primary Care" and "Concierge Medicine" practices. A couple of decades ago, DPC and Concierge physicians were met with uncertainty at best by patients, mistrust at worst. Now, in this time of uncertainty in the cost and quality of healthcare delivery, many are excitingly pursuing these alternatives.

5.5.1. Future Trends

Moving towards the future, one of the trends within the insurance market is looking towards improved customer satisfaction. This can be due to the enhancements of digital capabilities. A healthy ecosystem environment can create more meaningful digital engagement, tailored online services, and a continuous option and aid for digitally vulnerable clients. This is crucial during the COVID-19 time, as both insurance buyers and insurance companies live more online than ever before. People want to have the ability to make decisions and learn valuable information about their insurance needs while on a digital journey. The insurance market can answer these needs by making the customer journey more digitized and automatic; for example, having a smart chatbot available for clients who need assistance. A pleasant digital experience allows digitally aware clients an easy onboarding, improves their timeframe, reduces workload for the insurance agent, and lessens customer frustration. Further down the road, customers coming from across the various generations will be looking towards different capabilities and user experiences during their interactions with their insurance companies. Why is this of importance? Younger generations are enrolled in insurance business via digital channels but not closing the sale unless accompanied by an offline specialist.

A second viewpoint is towards a bigger customer service due to the addition of AI capabilities within the insurance. This can improve and enhance the conversations that digital agents are having with customers. Solutions using AI can make intelligent analysis of both voice and text, which provides business implications and enhancements to conversations. This feature gives an insurance company a greater understanding of why customers are contacting and what they are trying to achieve. Through conversations it's easy to evaluate sentiment, identify trends, and recognize call drivers in real time, thus increasing the overall customer experience. This is valuable when looking back on the customer surveys. Clients in the insurance industry will retain

insurance policies that create long-term benefits and company loyalty. Improved customer understanding and processing will increase customer satisfaction.

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