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Harmony Wealth Strategies
BUILDING AND SAFEGUARDING YOUR FINANCIAL WORLD

Private Health Coverage: Providers and Delivery Systems

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What is a health coverage provider?

A health coverage provider is the entity that provides the financing of your medical care. In some cases, a coverage provider may deliver medical care as well as financing, with physicians, hospitals, and insurers all participating in a business arrangement. For many years, traditional insurers were the only health coverage providers on the market. These are still a popular option. In recent years, however, managed health-care systems have become increasingly common. Managed health-care systems attempt to reduce health-care costs through preventative care and various utilization management techniques. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are both types of managed health-care systems. Other lesser-known types of managed health-care systems, such as the point of service (POS) plan and the exclusive provider organization (EPO), combine characteristics of HMOs and PPOs. The Patient Protection and Affordable Care Act (PPACA) added a new vehicle, called state Exchanges, through which individuals and small businesses can buy affordable health insurance after comparing health plans based on their benefits and costs. Subsidies are also available to supplement the cost of insurance for qualifying buyers.

About traditional insurers

The term traditional insurer refers to the common type of insurance company that has existed in America for decades. Policies issued by traditional insurers can vary greatly in terms of coverage. Some reimburse policyholders for covered expenses, while others make payments directly to providers. While many policies offered by traditional insurers contain a managed care element, others allow policyholders to retain complete freedom of choice with regard to health-care providers.

About health maintenance organizations (HMOs)

A health maintenance organization (HMO) is a type of managed health-care system that attempts to reduce health-care costs by focusing on preventative care and implementing utilization management controls. HMO members pay a fixed monthly fee for health-care coverage, and the HMO makes payments directly to health-care providers. HMOs only cover medical treatment provided by physicians and facilities within the HMO network. Under many HMO plans, you must choose a primary care physician (PCP), who is typically your first contact for all medical-care needs. The PCP provides your general medical care and frequently acts as the "gatekeeper" to the entire network. This means he or she is generally your first contact when seeking medical treatment and will either approve or deny any request to see a specialist.

About preferred provider organizations (PPOs)

Like a health maintenance organization (HMO), a preferred provider organization (PPO) is a managed health-care system. However, there are several important differences between HMOs and PPOs. A PPO plan is generally offered by an insurer in conjunction with a health insurance policy. Rather than being pre-paid for medical care, PPO physicians are paid as services are rendered. The PPO member may pay for the services and be reimbursed by the sponsor (employer or insurance company), or the physician may submit the bill directly to the insurance company. PPO members are not required to seek care from PPO physicians. However, there is generally strong financial incentive to do so. For example, members may receive 90 percent reimbursement for care obtained from network physicians but only 60 percent for non-network treatment.

About point of service (POS) plans and exclusive provider organizations (EPOs)

A point of service (POS) plan is a type of managed health-care system that combines characteristics of the HMO and the PPO. When you use a health-care provider within your network, POS coverage functions like coverage offered by an HMO. Generally, you also must choose a PCP who is responsible for all referrals within the POS network. If you choose to go outside of the network for non-emergency care, health care is covered at a lower level and the POS functions more like a PPO. An exclusive provider organization (EPO) is basically a PPO with one important difference: No coverage is provided for non-emergency non-network care. To an EPO member, then, the EPO seems to operate like an HMO. However, contractual issues, compensation arrangements, provider selection, and utilization management controls are handled like a PPO.

About state Exchanges

PPACA created state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges (SHOP) through which individuals and small business owners can buy qualified health insurance. To make it easier for insurance shoppers to compare plan benefits and costs, insurers participating in an Exchange must offer a uniform benefits package including four levels of benefits and costs. Plan benefit packages cannot discriminate based on an individual's age, disability, or life expectancy. In addition, subsidies and cost credits are available to lower income individuals to offset some of the premium expense.

How do you choose the right insurance provider?

In many cases, you will not have to make this decision. If, for example, you have employer-sponsored health insurance, your employer will have already chosen an insurance provider when the plan was established. If, however, you are looking for individual insurance coverage, or if your employer offers coverage from multiple providers, it is important to understand the differences between various types of insurance providers. Your decision will ultimately be a matter of comparison shopping in most cases. With the information available through state Exchanges, choosing the right insurance might be a little easier. Read our discussions on the various types of insurance providers for some of the major factors you should consider.

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