Razing a Tower of Babel: 
A Taxonomy for Managed Care and 
Health Insurance Plans

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Abstract  To many, the U.S. health care system has become an unintelligible alphabet soup of three-letter health plans. There is little agreement about which characteristics distinguish one type of plan from another. In this article we chip away at what has become a Tower of Babel of managed care and health insurance terminology. We review past and current trends in the market for nontraditional health benefit plans and propose a taxonomy, or system of classification, that will aid in understanding how managed care plans differ from conventional health insurance and from one another. Also included is a comprehensive glossary of terms.

Today, even seasoned observers are unable to distinguish different health insurance plans from one another. There is little consensus regarding labels and few accepted criteria for categorization, particularly for those health plans—now in the majority—that have come to be known as managed care plans. And the situation is worsening; seemingly, health plans with new rubrics are appearing every month.

This muddle goes beyond being merely academic. Employers, providers, insurers, policymakers, managers, regulators, analysts, and, especially, consumers are bewildered. It is commonplace for these different parties to talk past one another when addressing health insurance issues. This confusion not only affects the day-to-day functioning of the present health care system, it also is hampering effective communication in the

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arena for U.S. health policy reform. Furthermore, this confusion is being exported. A number of international initiatives, based largely on American managed care models, are spreading across western Europe and beyond (Weiner and Ferriss 1990).

This situation is contributing to an erosion of our knowledge base. In part, because there are few recognized taxonomies to serve as frameworks for analysis, empirical research documenting the advantages and disadvantages of different health insurance arrangements is becoming increasingly rare (Feldman et al. 1989).

In this article we attempt to chip away at what has become a Tower of Babel of managed care and health insurance terminology. We start by reviewing past and present trends in the market for conventional health insurance and managed care. Next, we propose a series of unifying concepts and a classification taxonomy that will make it easier to understand how managed care plans differ from one another and from health plans that are more traditional in nature. We go on to present estimates of the current market share of different health insurance arrangements.

Last, we present, as an appendix, a detailed glossary of terms. Like the article, it is targeted at a general health care audience. The glossary is intended as a practical user's guide for identifying and understanding the confusing array of health insurance plans and products likely to be encountered in the 1990s.

This paper's intent is not to argue the advantages or disadvantages of one model relative to another. Rather, our goals are to take stock and provide a framework for future discourse.

**Past and Present Trends**

**A Decade of Transition**

The 1980s witnessed an unprecedented change in the organization and financing of U.S. health care.

At the onset of the decade, two major health insurance arrangements existed, and one predominated. About 90 percent of working Americans and their dependents were covered by conventional "indemnity" health insurance plans purchased by employers as a benefit (Stoline and Weiner 1988). Under a typical employment-linked plan, consumers were free to choose any available provider. Physicians, for their part, were faced with few constraints and practiced more or less as they wished. Insurance companies usually served as passive go-betweens: the intermediary between
the employer and provider. With little scrutiny they paid bills submitted to them on a fee-for-service (FFS), retrospective basis. For the most part, insurers let providers determine the rates and terms of reimbursement. Like other indemnity-oriented policies, underwriting losses experienced by the carrier were ultimately passed through to the purchaser in the form of increased premiums.

The government-sponsored insurance programs—Medicare and Medicaid—although slightly less flexible, were patterned directly after this traditional employee health benefit model. Further cementing the similarities, private sector insurance companies performed most of the day-to-day management of the Medicare program.

The second major type of health insurance plan, the prepaid health maintenance organization (HMO), was the arrangement of choice for about 5 percent of all Americans in 1980. At that time, 80 percent of HMO enrollees received care from so-called closed staff- or group-model HMOs—where the physicians practiced in large, organized, multispecialty group settings. The remainder were enrolled in “open-panel” independent practice association (IPA) HMOs—made up largely of physicians practicing in small groups or solo, who wished to compete with the larger closed-panel plans (Interstudy 1991; Luft 1981).

By the end of the 1980s traditional insurance plans and established HMOs were joined by a stunning array of new health care financing and delivery entities. Collectively, these new plans (along with HMOs) came to be known as “managed care” plans or “alternative delivery systems.” Many believe that the old-line HMOs provided the paradigms for these new alternatives, but that the spark for their explosive growth emanated from employers, and to a lesser extent, government. As the financiers of the health care enterprise, these parties adopted aggressive cost containment methods in an attempt to manage rather than simply expend resources. By 1990, conventional (i.e., unmanaged) indemnity health insurance policies no longer covered the majority of Americans (Hoy et al. 1991; Gabel et al. 1990).

A Decade of Confusion

A common characteristic of the new managed care plans was the degree to which the roles of insurer and provider became integrated. Boundaries that once separated the two were blurred. The organizational, financial, and administrative approaches adopted by these novel plans were diverse. Though each took responsibility for managing resources, it did
so by developing its own patchwork of utilization monitoring and control mechanisms. In addition, some (following the HMO model) also shared monetary risk with providers, using nontraditional reimbursement schemes (such as prepaid capitation), and many channeled enrollees to providers with whom preferential contracts had been prenegotiated. Their benefit packages also varied significantly. In sum, there were several dimensions along which the health plans diverged from one another (Boland 1990; Goldfield and Goldsmith 1987; Gilman 1987).

Each managed care variant of the 1980s was dubbed (sometimes by a marketing agent) with a designation that broadcast its unique feature. These new monikers included network model plans, preferred provider organizations (PPOs), primary care networks (PCNs), competitive medical plans (CMPs), health insuring organizations (HIOs), triple-option plans (TOPs), exclusive provider organizations (EPOs), open-ended HMOs (O/HMOs), point-of-service (POS) plans, flexible plans, and single-benefit plans. Some have suggested (usually derisively) that because of the proliferation of acronyms, the U.S. health insurance market became an unintelligible alphabet soup of “three-letter health plans.” Moreover, this soup proved to be primordial; mergers, acquisitions, and tough competition led to a fast-paced evolution and hybridization of the first generation of plans, complicating matters further (Hoy et al. 1991; Gruber et al. 1988; Hale and Hunter 1988; Gabel et al. 1989; Gold 1991).

At the start of the 1990s, there were upwards of 2,000 corporately distinct health insurance and managed care entities (Interstudy 1991; AMCRA 1990a, 1990b; HIAA 1991). The responsibilities of these organizations, relative to the other parties in the health care financing arrangement, vary widely. Some insure, manage, and provide care; others are providers and managers only; and still others only administer. What usually distinguishes the managed care plans from those that are more traditional is that there is a party that takes responsibility for integrating and coordinating the financing and delivery of services across what previously were fragmented provider and payer entities. (We address this in more detail later.)

The insurance companies—the Blue Cross/Blue Shield plans and the 600-plus commercial carriers—are robust players on the field of managed care. Today, they are integral to the revolution that they to some extent helped cause by their inaction. Not only have they purchased or established their own free-standing delivery systems (as, e.g., HMOs) but the majority of private indemnity policies now apply managed care utilization controls borrowed from the alternative plans (Gabel et al. 1990). Some-
times this activity is performed in-house, but quite frequently stand-alone third-party administrators (TPAs) or utilization review (UR) firms—often labeled “managed care companies”—are hired to take on this responsibility.

A key factor contributing to the surge in managed care innovation and growth is the increasing number of employers who have seized direct control of their health benefit plans because of runaway costs. It is estimated that well over 50 percent of all employees are now in plans that are primarily self-insured; that is, where the employer does not purchase full coverage from an insurer (McDonnell et al. 1986; DiCarlo and Gabel 1989; HIAA 1991). Because self-insured (or self-funded) companies bear most risk themselves, they view health care expenditures as a direct drain on earnings. Understandably, many become quite aggressive and creative in developing approaches to limit health care outlays. Self-insured corporations were among the first to experiment with contractually negotiated health plans, such as PPOs, where providers agreed to special terms, like fee discounts and added utilization review scrutiny (de Lissovoy et al. 1987). To employers, the contractual approach to health care procurement seemed only natural; most of their day-to-day purchasing of other types of goods and services was done on such a basis. The models developed by and for self-insured companies have spread to many “full-premium insured employers” (i.e., those who purchase policies from insurers by paying premiums) and government.

Further confounding an easy characterization of managed care plans (or “products,” in marketing terminology) is that a typical plan is an interwoven lattice of numerous corporate entities. For example, when an employer offers a health benefit program to its employees, this plan may involve care delivered, insured, or managed by many legally autonomous organizations. One health plan may involve an insurance company, several freestanding networks of community providers (e.g., physician collectives and hospital consortia), several “single-benefit” or “carve-out” plans (e.g., dental, vision, and mental health plans), and a freestanding manager (e.g., a third-party administrator). This health benefit package, offered to the consumer as a seamless product, is in reality an amalgam of distinct organizations held together by intricate contractual linkages.

Another complicating factor is that most of the parties participating in one managed care plan are also involved in others. For example, it is usual for a hospital chain or a large physician group practice to contract with several different HMOs and PPOs. Also, insurance companies and managed care entities often sell multiple products. Most large insurers offer
an HMO, a PPO, and a managed indemnity product, and it is not uncommon for PPOs (or their holding company) to market an HMO plan, or for HMOs to offer a nontraditional "point-of-service" plan (where enrollees may choose their provider at the time they seek the care). Most third-party administrators, for their part, provide managed care support services to numerous self-insured employers or insurance companies.

A Taxonomy for Health Plans

We first describe the key features of typical health insurance arrangements. Then, using these features, we offer a categorization scheme that identifies the characteristics that distinguish different types of health insurance and managed care plans from one another.

The foundation of our taxonomy is the framework of contractual relationships—both formal and informal—that underlie all arrangements for medical care delivery and financing. Our main focus is private sector, employment-related group health plans, but we also attempt to make our paradigm relevant to public sector health entitlement programs.

Before presenting our framework, we briefly digress to summarize the process of health plan contracting.

The Contracting Parties

Contracting involves a bargaining and exchange process where each participant attempts to optimize a set of objectives. Contracts can be viewed as "conditions of participation" in any health plan. The four contracting parties involved in a typical health plan include

1. Consumers: Those persons who receive either direct medical care services or reimbursement for the consumption of services, as part of an organized health benefits program. In the case of private plans, these persons generally are the employees or pensioned retirees of a firm and their dependents. In the case of the governmental Medicaid and Medicare programs, people are entitled to a plan based on economic, medical, or demographic factors such as age, income, or disability status.

2. Sponsors: The employers (or sometimes unions) who sponsor group health benefit plans and pay the major portion of its ongoing costs—which include administrative costs as well as direct expenditures for medical care. For those persons insured by Medicaid or Medicare,
3. Providers: The independent clinical professionals (e.g., physicians) and institutions (e.g., hospitals) that furnish services to the consumer.

4. Intermediaries: These entities act, at a minimum, as the administrative conduit between sponsor, consumer, and provider; they see to it that bills are paid. Within many health plans, and especially those that deliver care through a network of contractually linked providers, intermediaries also bear responsibility for coordinating, managing, and integrating the activities of the providers. These entities include a range of corporations: traditional insurance companies, managed care plans (e.g., HMOs), and third-party administrators. These intermediaries may or may not bear risk, in the classic indemnity insurance sense. Medicare acts much like a self-insured employer and contracts with private sector intermediaries, as do some state Medicaid programs.

Dimensions of the Contracting Process

Each of the four parties identified above has a contractual relationship with one or more of the other parties. Some of these contracts are carefully negotiated written documents; others, are more informal social contracts, that is, expectations of behavior. Our discussion (and subsequent model) does not—and cannot—offer an exhaustive description of all the potential cross-party transactions. Rather, in a parsimonious fashion we identify those interactions that serve to distinguish and describe the major classes of health plans.

Health insurance plans exist mainly because of the consumer’s desire to share the financial risk arising from expenses associated with treating (or preventing) an illness or injury. The distribution of financial risk among several of the participants is represented in the first three elements we incorporate into our model. The next two elements revolve around the issue of choice: the choice of the consumer to seek care where he or she wishes, and the degree to which the provider is free to offer services to consumers bound only by professional dictates and ethics, licensing laws, and the incentives of an open marketplace. The last element we identify is the health plan’s obligation to provide care or to arrange for the provision of care.
Sponsor’s Financial Risk

As the sponsor and major bankroller of a health benefit program, the employer or government unit incurs ongoing administrative expenses, which are reasonably fixed, constant, and predictable. Additional expenses associated with the payment for medical care of plan members are also accrued. Most employers share the risk for this care-related expense with their employees by requiring payment of a portion of the anticipated expenses before care is sought and/or by requiring various degrees of cost-sharing once services are obtained.

Most employers (though not those with the most employees) contract with an intermediary to assume the majority of risk (DiCarlo and Gabel 1989). In such cases, once the employer pays a premium, the intermediary (e.g., an insurer or HMO) is at risk for resource costs associated with the employees’ care. Financial theory characterizes risk as “variance in expenditure.” The degree of variance depends on the number and health status of those enrolled. Risk decreases as the size of the group expands, due to the smoothing effect of large numbers. Because of this, self-insurance is particularly appealing to large firms; approximately 75 percent of companies with 1,000 or more employees are self-insured (McDonnell et al. 1986).

In theory, the extent of a sponsor’s risk spans the continuum between zero and 100 percent. Risk is minimized when the firm (or government unit) purchases full coverage for its beneficiaries via the payment of a fixed premium and is at a maximum when the sponsor is completely self-insured. Midway along the continuum lies a variety of arrangements for sharing a degree of risk among contracting parties. One common arrangement is for a firm to partially self-insure, through the purchase of a “minimum” premium plan (MPP) from an insurer who agrees to bear the risk (or “stop the loss”) for those events exceeding a predetermined threshold; for example, services amounting to over $50,000 per person in any given year.

Intermediary’s Financial Risk

In earlier times, the primary function of a health insurance firm was to underwrite the financial risk associated with a health benefit plan. However, in the model we present—and in today’s market for health plans—the intermediary’s level of risk bearing, like the employer’s, can also be placed on a continuum. There is no risk exposure to the “insurance
company” or third-party administrator that acts as the middleman for a self-insured corporation or government unit. In this type of role—where administrative services only (ASO) or claims service only (CSO) are provided—it is the function of the intermediary to manage the flow of funds. Profit is derived from fees associated with management services, instead of the spread between premium revenue and payment to providers. The intermediary’s risk exposure is greatest within a traditional indemnity plan or a traditional HMO, where all services must be paid out from the premium revenues (although losses for one year can, to a degree, be recouped by increasing premiums for later periods). The middle ground of risk exposure arises when the intermediary shifts a portion of this assigned risk to the other contracting parties, that is, to the consumer or provider.

Consumer’s Financial Risk

Consumers are sensitive to risk. Historically, they have faced only moderate risk under most private indemnity plans and Medicare, because deductibles and coinsurance were reasonably modest. This is changing: among employers there is a gradual trend towards increasing the patient’s share of the cost of care (Jensen et al. 1987; Gabel et al. 1990). This issue has become central to the labor contract negotiation process. Because consumers understandably prefer to be covered for all charges, from the first dollar (“first-dollar coverage”), managed care plans can compete with traditional plans on this feature. For example, HMOs present the consumer with minimal cost sharing of preventive and therapeutic ambulatory services, so as not to create financial disincentives to seek such care (GHAA 1990).

Provider’s Financial Risk

Only recently has acceptance grown for the idea that providers who participate in an integrated managed care system might bear some financial risk. Under traditional reimbursement arrangements, the provider was not exposed to risk because remuneration was based on costs (or, more accurately, charges). Financial risk is highest when a provider agrees to a budgeted or capitated (per head) payment where all necessary care must be delivered in return for a fixed annual (or monthly) fee. The middle ground of provider risk includes arrangements such as prospectively set, per case fee payment—like Medicare’s prospective payment system, which is based on fees for diagnosis-related groups (DRGs) of treatments—and
mechanisms where providers, though reimbursed via a conventional fee-for-service system, are at risk of a penalty or reward, depending on some retrospective measure of their efficiency. Use of "withholds," where a portion of a fee-for-service or capitation payment—say 20 percent—is withheld from the provider and not returned unless a certain target is met, is an example of this approach (Kongstvedt 1989; Hillman 1987; Hillman et al. 1989).

Consumer's Freedom of Choice

The degree to which a consumer is free to select a provider (e.g., a primary care physician, specialist, or hospital) is the next dimension of the contracting process to consider. The consumer's ability to choose a caregiver is not restricted under most traditional fee-for-service indemnity plans; services may usually be sought from any licensed provider in the country. Restrictions of consumer choice are at a maximum in a closed health plan, such as an HMO or what is called an exclusive provider organization (EPO). In these types of plans, consumers must select a provider from a roster of those employed by or under direct contract to the plan. Midway between these extremes are managed care arrangements (e.g., PPOs or so-called point-of-service plans) that offer incentives to use a subset of providers, but where the ability to seek covered services from other providers is still retained.

Provider's Practice Choices

Practitioners prize autonomy: the freedom to independently prescribe and administer clinical services guided only by ethics, medical science, and marketplace interests. The common feature of all managed care plans is an extensive system of utilization controls. Such programs subject many facets of the patient's use of health services—and, accordingly, the provider's practices—to review by some external utilization review entity. These controls are one of the mechanisms used to "manage" the patient's care and ultimately the sponsor's resources.

Cost containment is paramount to utilization review programs. However, well-conceived review standards or guidelines can also be considered as a tool for enhancing the quality of care, particularly as it relates to reducing the incidence of unneeded, "inappropriate" interventions. This is a point of contention among many providers.
Restrictions on a practitioner’s clinical options are usually greatest in closed network, “fully managed” delivery systems (e.g., HMOs). In these settings many, if not most, practices come under the scrutiny of concurrent treatment or retrospective utilization review. There are probably more restrictions in independent-practice-association HMOs than in staff- or group-model HMOs. In large organized groups, “practice culture” (i.e., a more subtle socialization process) often serves as a source of control, rather than explicit utilization criteria. Restrictions on providers are minimal in traditional indemnity plans. The managed care territory that falls between these two extremes is vast and varied.

Since virtually all private and public insurers now apply at least some utilization controls, the question of demarcation between “managed” and “nonmanaged” care arises. Most analysts consider the line is crossed when physicians lose their ability to hospitalize nonemergency patients without first obtaining prior authorization or “certification” from the intermediary or its agent.

The Contractual Obligation to Provide Care

Several decades ago, traditional insurers came to be known as the third parties because they neither demanded care (as does the first party) nor supplied care (as does the second party). Rather, theirs was a third role: that of bill payer, with no further obligations. In most managed care systems, the contractual obligations of the insurer (or other type of intermediary) has moved far beyond the traditional third-party role. The responsibilities have crossed over into areas formerly reserved for the other two parties. In many managed care plans, the intermediary is legally committed to provide care, or to arrange for its provision, via a network of providers with which it has prenegotiated contracts.

In a few managed care systems, e.g., some staff-model HMOs, where the intermediary is fully integrated and corporately indistinct from the physician group, the insurer actually becomes the second party and provides services directly.

Within other closed network managed care plans (e.g., group-, independent-practice-association-, and network-model HMOs, and exclusive provider organizations) the intermediary does not actually provide care. Instead, it is committed to arrange for the delivery of care by providers in its network.

Within open-ended plans (e.g., PPOs, open HMOs, and other point-of-
service plans), where the consumer retains some ability to use providers from outside the system, the organization is legally committed to arrange for the provision of care only if the consumer wishes it to do so.

**Applying the Model**

We have identified four major parties that may share financial risk within a health plan arrangement: consumer, sponsor, intermediary, and provider. We have identified two elements of choice: those affecting consumers and those affecting providers. And we have discussed the issue of contractual obligation to provide care. We offer a categorization scheme that distinguishes the major types of health plans from one another, based on six of these dimensions. We do not use consumer risk sharing as a distinguishing feature in this scheme, because it may be present at varying levels (or not at all) within any type of health plan. Our classification matrix is presented as Table 1.

One axis of Table 1 presents what we consider to be the six major categories of health plans: (1) conventional fee-for-service indemnity plans; (2) managed indemnity plans; (3) preferred provider organizations; (4) exclusive provider organizations; (5) open-ended health maintenance organizations; and (6) nonopen (or "pure") health maintenance organizations.

The other axis of Table 1 presents the six criteria that can be used to distinguish and characterize each plan. For each of the six dimensions, the table indicates the presence or absence of the identifying element across the six major health plan categories.

The initial criterion in Table 1—the sponsor's financial risk—can be either present or absent within the first four health plan arrangements, depending on whether the sponsor chooses to purchase full-premium insurance or to bear the risk itself. The two classes of HMOs remain the only major categories where it is not generally feasible for the plan to share the risk with the sponsor, since prepayment of a premium is essential to the HMO concept. By itself, however, this element cannot be used to identify an HMO, because in other types of plans intermediaries may (or may not) also retain risk.

The second element of the matrix, intermediary's risk, in general runs counter to the first; when the sponsor is at risk, the intermediary will not be, and vice versa. Together, the first and second elements of the matrix identify the extent to which the sponsor and intermediary hold stakes in the plans' financial efficiency. This risk may or may not be shared significantly by an intermediary, except, as noted, in the case of the two classes
### Table 1 A Taxonomy for Categorizing Health Insurance Plans

<table>
<thead>
<tr>
<th>Dimension</th>
<th>FFS</th>
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<th>PPO</th>
<th>EPO</th>
<th>O/HMO</th>
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<td>Physicians Assume Financial Risk</td>
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<td>Significant Utilization Controls</td>
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**Key.** FFS: “traditional” fee-for-service indemnity plan; MIP: managed indemnity plan; PPO: preferred provider organization; EPO: exclusive provider organization; O/HMO: open-ended health maintenance organization; HMO: health maintenance organization (including independent practice association).

- absent; + present

**Note.** See text and glossary for further explanation.

- The left side of the slash reflects a plan where an employer purchases a full-premium benefit from the insurer. The right side reflects a self-insured (or minimally insured) private plan or a government plan where risk resides with the sponsor.
- Primary care physicians at a minimum, but may also involve other providers.
- In PPOs and O/HMOs, consumer’s choice is limited through incentives and disincentives rather than mandatory restrictions. They have the option to seek covered care from outside the plan. The right side of the slash reflects care when this “out-of-plan” option is exercised.
- Usually defined as mandated “prior-authorization” for nonemergency hospitalization.

of HMOs, where the plan always bears the majority of risk. (Note—a small number of HMOs and some open HMOs are experimenting with ways to share risk with self-insured employers.)

It is not typical for a freestanding PPO to share significant risk associated with services, because it cannot be predicted whether, or to what extent, care will be delivered by providers from within its network. However, when the PPO entity (or its parent or sister corporation) can structure contracts so that it is at risk for use outside of the PPO network as well as use within it, it is possible for the PPO to become a risk-bearing entity. These “unified” PPOs can be considered one type of point-of-service
plan. The consumers are guaranteed some coverage by the plan wherever they go for care. (Note—non-unified PPOs are not generally considered point-of-service plans. We’ll discuss other types of point-of-service plans later.)

An exclusive provider organization (EPO) may or may not bear risk. A risk-sharing EPO (R/EPO) is in most cases very similar to an open-panel independent-practice-association HMO, except it does not share risk with providers. A number of prototype government-sponsored plans, known as health insuring organizations (HIOS) and Medicare insured groups (MIGs) can be considered examples of risk-sharing EPOs (U.S. GAO 1985, 1989; Freund and Hurley 1987). Within these types of plans, an intermediary, corporately distinct from either the sponsor or the provider, is legally committed to procure care for a fixed sum of money.

The third element of the matrix is the placement of significant risk on the primary care physician or the corporation in which he or she is employed. This characteristic is present only within plans that we categorize as members of the HMO family. Risk may be shared with physicians via salary (as in most staff-model HMOs), via capitation, or through the sharing of risk via monetary rewards or penalties that are directly linked to the behaviors of individual physicians or their corporation (Hillman 1987; Hillman et al. 1989).

HMOs have adopted a variety of organizational arrangements, which are described more fully in the glossary. Other researchers have developed innovative taxonomies for classifying the different HMO types (Zelten 1979, 1981; Welch et al. 1990; Welch 1987).

Various profit-sharing arrangements are sometimes offered to physicians participating in non-HMO network-based health plans (e.g., exclusive provider organizations or PPOs), but these do not meet the risk-sharing criteria defined above. For example, some plans may offer company stock or share corporate profits with providers, but the linkage between clinical action and reward is not direct.

The fourth element of the model outlined in Table 1 is the level of restrictions placed on the consumer’s freedom to choose providers. We view noncoverage of care from out-of-network providers as the maximum constraint and full coverage of any provider as the ultimate freedom. The degree of restrictiveness is an element that differentiates plans. A PPO can be distinguished from a managed indemnity plan (MIP) by the fact that in an MIP, consumers face no restrictions or incentives intended to keep them within a limited network of providers. (It should be noted, however, that in most MIPs, as in other indemnity plans, consumers may select...
a "participating" provider or one who accepts "assignment" in order to lower their out-of-pocket costs. We do not view this as a significant restriction.) An exclusive provider organization can be distinguished from a PPO by the fact that in the former consumers must use providers in the network in order to have services covered. Open-ended HMOs are distinguished from conventional HMOs by their "escape hatch," where some coverage is offered for out-of-plan use.

The term open-ended (or open) HMO encompasses entities often called by other names. Alternative designations include HMO hybrids, point-of-service plans, or point-of-service HMOs. What all have in common is that they are based on a conventional HMO that allows the enrollee to choose a provider either in or out of the network.

There are (at least) three types of point-of-service plans, two of which we have already described. Some are unified PPOs, others are open HMOs, and others are different again. In some point-of-service plans, consumers are offered three choices. Each option involves different levels of coverage, linked to different classes of providers. It amounts to a choice between something like an HMO (or exclusive provider organization), a PPO, and a managed indemnity plan. Unlike the so-called triple-option plan, where consumers must preselect one of the three plans during a yearly "open enrollment" period, in a three-way point-of-service plan, they can choose the provider at the time care is sought.

Most point-of-service plans bear risk, but, with the exception of open HMOs, they usually do not share risk with physicians. Point-of-service plans are gaining popularity with self-insured employers, because, unlike standard PPOs and HMOs, they can more easily share risk with the employer. The structure of point-of-service plans is in considerable flux.

The last two elements on Table 1—significant utilization controls and obligation to provide care via a network—can be used to distinguish between managed care and traditional indemnity plans. They also serve to group the five types of managed care plans into two broad classes.

Managed or Integrated?

The use of managed care practice controls—at a minimum, preadmission certification—is the element that distinguishes the five types of managed care plans from nonmanaged indemnity plans.

The managed care plans listed on Table 1 fall into two major families, those that are "integrated delivery systems" and those that are not. An integrated delivery system is a health plan where
1. There is a legal responsibility to deliver medical services to enrolled consumers who seek care from within an integrated network of providers employed by, or under contract to, the plan.

2. There is an entity that manages care by controlling the patterns of practice of providers in the network. This is accomplished by administrative and possibly financial controls. These include, at a minimum, mandated precertification of major services and retrospective profiling of provider practices via information systems.

The various types of HMOs, open HMOs, PPOs, and exclusive provider organizations are the four major classes of integrated delivery systems. Point-of-service plans (most of which are open HMOs or unified PPOs) also fit into this family.

The other important type of managed care plan—the managed indemnity plan—cannot be considered a fully integrated delivery system. These plans generally represent conventional insurance plans with utilization review cost controls grafted onto them. However, as indicated on Table 1, the intermediary is not obliged to arrange for care through a network of providers.

It should be noted that there is some movement away from the term managed care to describe the managed indemnity plan. Within the private sector, the so-called traditional indemnity plan is no longer so traditional—at least when compared to the plans of ten years ago. In response to this trend (and also as part of a public relations strategy), the Health Insurance Association of America (HIAA) recently changed its corporate definition of managed care to exclude managed indemnity plans. What we term a managed indemnity plan, the HIAA now calls an indemnity plan with utilization review. The major criterion they use to define a managed care plan is the existence of a coordinated network of providers (which is close to what we term an integrated delivery system). Complete consensus on the use of the term managed care still does not exist.

Based on our preceding taxonomy, the work of others, and terms in common usage, we have developed a comprehensive glossary (Appendix). It offers definitions of not only the major classes of health plans we have discussed but also numerous variants and subclasses of plans. The terms in the glossary are ordered alphabetically. Given the general lack of consensus for some concepts, we propose a preferred term along with others in common usage.
The Current Market Share of the Health Plans

Figure 1 provides 1990 estimates of the proportion of Americans insured by four major groupings of health benefit plans. These estimates are based on recent published and nonpublished sources (HIAA 1991; Gabel et al. 1990; Interstudy 1991; HCFA Office of Research and Demonstrations internal memo, November 1991). The figure presents the proportion of persons enrolled in each of four plan groupings across several major segments of the U.S. population. The four broad classes of health plans are: (1) traditional (unmanaged, nonintegrated) indemnity plans; (2) managed (nonintegrated) indemnity plans; (3) preferred provider organizations (including exclusive provider organizations and point-of-service plans not offering an HMO option); and (4) health maintenance organizations (including open-ended HMOs and point-of-service plans offering an HMO choice).

Approximate market shares of each of these types of plans are presented for both private programs (covering about 69 percent of Americans) and the two main public sector programs (covering about 18 percent of Americans). The estimated proportion of persons (13 percent) without health plan coverage is also presented for the sake of completeness.

Within the privately insured segment of the population, we further subdivide those who are covered by group policies received as a benefit of employment and those who purchase policies as individuals. (Note—a proportion of these individuals may purchase a group policy through a professional or fraternal organization.) Within the employment-sponsored plans, we further subdivide between those employers who are mainly self-insured and those purchasing full-premium policies from an intermediary.

The differences in the estimated market share of each type of plan across the population segments are striking. The managed care plans are most common among those offered through places of employment, particularly where the employer is self-insured. Managed care programs are much less common among those purchasing insurance individually.

Most of the care reimbursed by the public sector is not delivered by managed care plans. About 4 percent of Medicare beneficiaries are enrolled in HMOs on a “risk-contract” (so named because the HMO is at risk) basis (another 2.5 percent receives cost-based services from HMO providers) (HCFA Office of Research and Demonstrations internal memo, November 1991). Although it is considering and experimenting with alternatives, Medicare has no other large-scale managed care program. We estimate that in 1990 about 5 percent of Medicaid eligibles are in conventional...
HMOs and another 5 percent are in PPO variants (notably risk-sharing exclusive provider organizations). An estimated 10 percent are in various fee-for-service case management systems, where a "gatekeeper" must precertify referrals and/or hospitalizations (Freund and Hurley 1987; Hurley and Freund 1988; Spitz and Abramson 1987; HCFA Office of Research and Demonstrations internal memo, November 1991).

Figure 2 provides a summary of the estimated 1990 market penetration of each type of health plan among all insured Americans. Separate charts for those insured through private and public programs are also presented. In 1990, approximately 15 percent of Americans were in one or another type of HMO and 14 percent were eligible to use PPO providers. Of the persons in either a PPO or HMO, we estimate that about 10–20 percent—or about 5 percent of all insured Americans—were in hybrids such as open-ended HMOs, exclusive provider organizations, or point-of-service plans. About 34 percent of all Americans were in a managed indemnity plan and the remaining 37 percent were in a nonmanaged indemnity in-
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Figure 2 Estimated Market Share of Health Plans for Americans Insured by Private and Public Programs and Overall

FFS = Traditional fee-for-service indemnity plan.
MIP = Managed indemnity plan.

...insurance plan without any significant degree of utilization management or integration of provider and payer. As noted earlier, the distribution varies dramatically across sectors. We estimate that in 1990 persons privately insured were almost seven times as likely to be enrolled in managed care plans than people insured by public programs.

The 1990s and Beyond

There is general agreement that health plans will continue to blend along the margins of the managed care continuum. For example, PPOs are likely to mimic HMOs by adding restrictions and controls (e.g., attempting to minimize use of providers outside the network), and HMOs will compete with PPOs by “opening up” (i.e., covering some out-of-plan use).
It also appears that those plans representing hybridized models—melding the traits of two or more classes of plans—will proliferate. These mixed models include exclusive provider organizations, open HMOs, and the various types of point-of-service plans.

Conventional indemnity plans will, in all likelihood, continue to adopt the aggressive utilization review methods now used by managed indemnity plans. So much so, that in the near future the term *conventional indemnity* probably will more aptly describe what we have termed the *managed indemnity* plan.

Changes mandated by government could have dramatic effects on the future of U.S. health plans. If a national health program were to be adopted, many believe it should be developed around a managed or integrated care model (Enthoven and Kronick 1989). This, of course, would have a very significant impact on those private plans participating in such a reformed system. Having less drastic, but still far-reaching effects, would be policy changes within the existing Medicaid and Medicare programs. For example, by strongly promoting (or mandating) one or another managed care model, the Health Care Financing Administration could reshape the health plan market overnight. Also, several states already have, or may soon implement, wide-scale managed indemnity plans within their Medicaid programs. This trend is likely to continue.

Although prognostication in these turbulent times is dangerous, some things seem fairly certain. The managed care and integrated care concepts are now the mainstream and have redefined the very nature of the American health care delivery system. Health plans will continue to innovate, evolve, and hybridize; entities that reflect yet unseen organizational and financial arrangement will be a likely result. Categorizing, and even just describing health plans will become ever more difficult. The need for standardized taxonomies and definitions will be urgent.

**Appendix**

**A Glossary of Managed Care and Health Insurance Terms**

*Alternative delivery system (ADS).* A generic term for new systems seen as alternatives to traditional fee-for service (FFS) indemnity health insurance plans. ADSs usually involve a significant degree of integration between payer and providers. The ADS entity is legally committed to pro-
vide care or to arrange for its provision through a network of providers. The ADS entity also manages this care. The two major types of ADSs are HMOs and PPOs. ADSs are rapidly becoming mainstream; the term alternative is somewhat of a misnomer and is being used less frequently. We propose the term integrated delivery system. (See also managed care, HMO, PPO.)

Carve-out plan. See single-benefit plan.

Case management (CM). (1) An arrangement where a “case manager” who is not a physician (usually an RN or MSW) serves as a medical ombudsman responsible for coordinating the care process for selected consumers. Case managers usually work with patients having expensive conditions (e.g., those with AIDS or cancer, and premature neonates). We suggest that this is the appropriate use of the term. (2) Sometimes used interchangeably with managed care. (3) An arrangement where a “gatekeeper” physician must deliver or approve the delivery of all care. (See gatekeeper and coordinated care.)

Competitive medical plan (CMP). A term used by the U.S. Health Care Financing Administration (HCFA) for a subset of the organizations that have “risk contracts” to serve Medicare beneficiaries on a capitated payment basis (based on an adjusted average per capita cost, or AAPCC). HCFA does not consider these organizations to be HMOs, because they are not federally qualified (by HCFA’s Office of Prepaid Health Care, OPHC). This term is sometimes used interchangeably with ADS.

Coordinated care. A term HCFA often uses more or less generically for managed care plans, particularly if they make use of gatekeepers.

Exclusive provider organization (EPO). A type of PPO (see PPO) where the patient must “exclusively” use the providers within the PPO. This characteristic is sometimes called a lock-in provision. If the EPO entity bears risk that is directly related to utilization of its enrollees, it can be categorized as a Risk-sharing EPO or R/EPO. (See R/EPO.)

Gatekeeper. A primary care physician (i.e., a family practitioner, internist, or pediatrician) who is responsible for coordinating all services. In a gatekeeper plan, most elective specialist or hospital care cannot be delivered without the gatekeeper’s approval. This system is used by most
HMOs and EPOs. In HMOs, the gatekeeper is usually placed at financial risk for referral and hospital care, a condition that serves as a disincentive to "open the gate." In non-HMOs, the gatekeeper does not share risk and is paid separately for gatekeeper services. State Medicaid programs use this approach fairly extensively and often label gatekeeper physicians *case managers* (see above). There have been some instances of physicians forming networks to offer their coordinating services to integrated delivery systems that choose to purchase them. Such freestanding groups of gatekeepers have sometimes been called *primary care networks*.

**Group-model HMO.** A type of HMO where a single large multispecialty group practice is the sole (or major) source of care for an HMO's enrollees. The group may or may not have existed before the corporately distinct HMO entity formed, but it has an exclusive contract only with the one HMO. Some groups also see fee-for-service or PPO patients; others are not allowed to do so. Because of the similarity with the staff-model HMO, the term *staff/group-model HMO* is often used to denote these large HMOs. (See also *HMO* and *network HMO*.)

**Health insuring organization (HIO).** See risk-sharing EPO.

**Health maintenance organization (HMO).** A prepaid organized delivery system where the organization and the primary care physicians assume some financial risk for the care provided to its enrolled members. Often, the physicians serving HMO patients are paid on a capitation basis. The HMO is legally committed to provide care to its enrollees. In a *pure HMO*, members must obtain care from within the system if it is to be reimbursed. The term *HMO* was coined by Paul Ellwood for the Nixon administration in 1972. This constituted a renaming of two existing delivery models: prepaid group practices (PPGPs), or closed-panel plans, and independent practice associations (IPAs), or open-panel plans. (The *panel* refers to the panel of physicians available to the member.) The earliest PPGPs were often founded by socially conscious consumer collectives patterned loosely after European sick funds. In most of the early HMOs, the financing and delivery of care were very closely integrated. For example, these HMOs did not reimburse physicians for their services, they hired them directly. Today, there are four basic HMO models (staff, group, network, and IPA) and several related variants and hybrids. (See also *group HMO*, *staff HMO*, *IPA*, *network HMO*, *mixed-model HMO*, *S/HMO*, *O/HMO*, and *risk-sharing EPO*.)
Hybrid health plan. See point-of-service plan.

Independent practice association or individual practice association (IPA). An open-panel type of HMO where individual physicians (or small group practices) contract to provide care to enrolled members. The primary care physicians may be paid by capitation, or by fee-for-service with a "withhold" risk-sharing provision. An IPA entity may or may not be legally distinct from the HMO entity with which the member enrolls. Physicians participating in IPAs retain their right to treat non-HMO patients on a fee-for-service basis. Most of the early IPAs were developed by organized medicine to compete with large closed-panel HMOs. Many of these initial plans were sponsored by local medical societies and were known as foundations for medical care (FMCs). (Many FMCs also were the sites of early professional standards review organizations, PSROs. See also HMO and network HMO.)

Integrated delivery system. See alternative delivery system.

Managed care. A term often used generically for all types of integrated delivery systems, such as HMOs and PPOs, implying that they "manage" the care received by consumers (in contrast to traditional fee-for-service care, which is "unmanaged"). More recently, this term is often used to denote the entire range of utilization control tools that are applied to manage the practices of physicians and others, regardless of the setting in which they practice. In addition to being used in all HMOs, PPOs, and EPOs, these controls are increasingly being applied to conventional fee-for-service indemnity plans (see managed indemnity plan). The types of methods used to manage the patient's care may include preadmission certification, mandatory second opinion before surgery, certification of treatment plans for discretionary nonemergency services (such as mental health care), primary care physician gatekeepers and nonphysician case managers to monitor the care of particular patients. The actual managing organization is frequently an entity separate from the payer or insurer. Among managed indemnity plans, this type of organization is often called a managed care company or third-party administrator (see TPA). The term managed care is sometimes used (especially among Medicaid agencies) to denote a case manager program. (Also see ADS, case manager, coordinated care, MIP.)

Managed competition. A model proposed for national health care reform,
where independent plans (primarily, integrated managed care plans) compete with one another in a market closely regulated by government. In this case, it is the health plan that is being "managed."

**Managed indemnity plan (MIP).** A type of health plan where the insurer (or its agent) uses a significant number of utilization controls to manage the practices of providers it reimburses. These controls are more extensive than those used in traditional indemnity plans. Providers are paid on a fee-for-service basis and a variety of mechanisms may be used to determine rates of payment. A plan is not usually considered an MIP if it does not mandate preadmission certification for elective hospitalizations. (See also managed care.)

**Medicare-insured group (MIG).** See R/EPO.

**MeSH (medical staff and hospital).** A joint venture, where a hospital (or hospitals) and its private practice medical staff (or other body of independent physicians) form a corporation. This MeSH entity, as a unit, may then contract to provide in-patient and/or ambulatory care to patients enrolled in an HMO or PPO (which is corporately distinct from the MeSH). The MeSH can also become a PPO or HMO by directly negotiating with employer groups or payers and by relating to outside providers on a contractual basis.

**Mixed-model HMO.** An HMO that is a mixture of the relatively distinct staff, group, network, or independent practice association (IPA) varieties. For example, an HMO that serves a significant proportion of its enrollees within a staff model site, but also contracts with several other groups or IPA entities, may be of this type. An HMO can be mixed-model when assessed within a particular market area or across areas. These types of HMOs are becoming more common, as HMOs of one model acquire or merge with previously distinct HMOs of a different type. The results of such mergers are frequently known as network model HMOs. (See also network HMO and O/HMO.)

**Network-model HMO.** A type of HMO where a network of two or more existing group practices has contracted to care for the majority of patients enrolled in an HMO plan. A network-model HMO sometimes also contracts with individual providers in a fashion similar to an IPA. Providers contracting with this type of HMO are usually free to serve fee-for-service
patients as well as those enrolled in other HMOs and PPOs. The term network/IPA is often used to encompass both this and the IPA-model HMOs. (See also IPA and HMO.)

*Open-ended HMO or open HMO (O/HMO).* A type of HMO where the enrollees are not "locked in"; they may leave the HMO and still have certain services covered. Such "out-of-plan" utilization is usually subject to a significant degree of cost sharing (e.g., deductibles), unlike those services delivered within the plan. The out-of-plan segment of HMO use may fall within an existing nonmanaged indemnity plan, MIP, or PPO run by the HMO or its parent corporation. To be considered an O/HMO, the plan must retain all risk and the primary care physicians must share in this risk. This usually includes the risk associated with out-of-plan use. These plans are sometimes termed *point-of-service (POS) HMOs, hybrid HMOs, HMO swing-outs*, and *flexible HMOs.* (Plans using these labels often share some risk with employers.) Currently, this class of plan is still somewhat loosely defined. Many point-of-service plans, which are not linked into an existing pure HMO, would more accurately be classified as PPOs or a type of triple-option plan. (See also PPO and TOP.)

*Point-of-service (POS) plan.* A point-of-service plan is a hybridized managed care plan that offers the consumer a choice of options at the time he or she seeks services (rather than at the time they choose to enroll in a health plan). There are (at least) three types of POS plans: 1) An open HMO; 2) A triple-option plan; and 3) a "unified" PPO. POS plans are also known as *flexible health plans, mixed-model health plans*, or *hybrid model plans.* (See open/HMO, TOP, and PPO.)

*Preferred provider arrangement (PPA).* Similar to a PPO, except purchasers selectively contract directly with a provider, usually without benefit of a comprehensive administrative entity like a PPO. Usually, no significant managing of care takes place in PPAs. (See also PPO.)

*Preferred provider organization (PPO).* A PPO is a type of integrated delivery system where the PPO entity acts as a broker between the purchaser of care and the provider. In a PPO, consumers have the option of using the "preferred" providers available within the plan, or not. Consumers are channeled towards in-plan providers by incentives and disincentives (relating to cost-sharing provisions and benefit coverage). In return for the patient referrals, providers agree that their care will be "managed."
Providers are usually paid a discounted fee-for-service payment (e.g., 80 percent of their usual fee) and they do not participate in financial risk sharing. A “unified” PPO is a plan that bears risk for both in-plan and out-of-plan use. These plans are sometimes marketed as point-of-service plans. (See also POS plan and EPO.)

Risk-sharing exclusive provider organization (R/EPO). An exclusive provider organization (see EPO) where the organization shares a significant amount of risk with the payer. Unlike an IPA-model HMO, the R/EPO does not share any of this risk with its primary care physicians (e.g., via capitation or withholds). A health insurance organization (HIO) was a type of R/EPO. It was a plan developed to contract with a state’s Medicaid administration to provide care on a prepaid basis only to Medicaid enrollees. Legislation all but eliminated these and other plans serving 100 percent Medicaid enrollees. Another prototype plan proposed for Medicare beneficiaries and known as Medicare-insured groups (MIGs), is also a type of R/EPO. MIGs are collectives of Medicare beneficiaries, such as union- or employer-related groups, that receive a predetermined capitation amount for a defined population of beneficiaries. The MIG assumes all risk for purchasing the care for those enrolled.

Single-benefit plan. An entity that subcontracts with other organizations, e.g., HMOs, indemnity insurers, or EPOs (usually on a capitated basis), to provide health services only within a “single benefit” category. Single benefit plans have been set up to provide mental health, dental, or eye care only. The providers in these plans may or may not participate in risk-sharing arrangements, but the plan itself usually is at full risk for the services it contracts to provide. These plans are often termed carve-out plans, because selected services are carved-out of the full array of coverage offered by the main insurer. (Also known as single-benefit HMOs.)

Social HMO (S/HMO). A type of HMO developed mainly on a demonstration basis with HCFA funding. It is intended to expand traditional HMO medical services to provide social support and long-term care to elderly and disabled enrollees. The S/HMO arrangement may revolve around a conventional HMO that contracts with a long-term care provider, a long-term care agency that contracts with medical providers, or an independent broker that contracts with all providers. (See also HMO.)

Staff-model HMO. A type of HMO where the majority of enrollees are cared for by physicians who are on the staff of the HMO. Although these
physicians may be involved in risk-sharing arrangements, a majority of their income usually is derived from a fixed salary. The “group cooperative” consumer-controlled HMOs are usually staff-model plans. Because the physicians in this type of HMO are also organized in groups, the label group/staff-model is used to encompass both this and the group-model HMO. (See also HMO and group-model HMO.)

Third-party administrator (TPA). A private firm that serves as the agent or intermediary of a health plan when dealing with providers. These firms can be considered distinct corporate entities, separate from the health plan or insurer. (Through sister or parent corporations, however, many TPAs do offer their own health plans.) TPAs are responsible for at least some (if not all) administrative functions, but a TPA bears no financial risk associated with the insurance function. Some TPAs handle the claims payment process. Many TPAs manage the care paid for by the at-risk entity (e.g., the plan or employer). A TPA performing this function is often known as a managed care or utilization review (UR) company. TPAs are most frequently retained by self-insured employers, but increasingly, nationally oriented managed indemnity plans, PPOs, independent practice associations, and point-of-service plans are using their services. (See also managed care.)

Triple-option plan (TOP). A “single” plan (or a collection of contractually linked freestanding plans) that offers a consumer the choice of three health benefit options at the time of enrollment. TOPs offer an HMO, a PPO and a managed indemnity plan (or a nonmanaged indemnity plan) under the same corporate umbrella. TOPs are often coordinated or owned by insurers who have formed or acquired freestanding HMOs or PPOs. To be considered a TOP plan, the risk for all plan options must be retained by a single entity. To an employer, a key advantage of a TOP (vs. non-linked plans offered to employees by separate insurers) is that the issue of “biased selection,” where healthier employees select one plan over another is avoided; the same insurer bears the risk, regardless of which plan an employee chooses. A TOP that offers the consumer three choices at the point of service (rather than at the time of enrollment) is usually termed a point-of-service plan. (See also POS plan.)


