HEALTH PLANS

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OUTLINE

- What is a health plan?
- What are the different types of health plans and what are quality measures?
- What are some risks for insurance companies and how can they be managed?
- How are health plans financed?
- What is the future of health care and health plans?

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HEALTH CARE AND HEALTH PLANS

- HEALTH CARE: Organized provision of medical services for the maintenance and improvement of physical and mental health.

- HEALTH PLAN: Contract that helps pay for some or all of health care costs.

  - TAXPAYER-FUNDED: Funded by federal and states taxes.
    - Ex: Medicare and Medicaid

  - PRIVATE-FUNDED: Primarily funded through benefit plans provided by employers.
    - Ex: Blue Cross and Blue Shield

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EXAMPLES OF PLAN TYPES

- EXCLUSIVE PROVIDER ORGANIZATION (EPO)
  - Requires consumers to only use providers within network; payment is on a fee-for-service basis
- HEALTH MAINTENANCE ORGANIZATION (HMO)
  - Limits coverage to care from contracted doctors.
  - Provide integrated care and focus on prevention and wellness.
  - Ex. Kaiser Permanente
- POINT OF SERVICE (POS)
  - Health care professionals under the network cost less.
    - Specialists require a referral.

EXAMPLES OF PLAN TYPES

- PREFERRED PROVIDER ORGANIZATION (PPO)
  - Health care professionals under the network cost less.
    - Out of network care requires an additional cost but no referral.
- MEDICAID
  - Provides coverage for individuals and families with different or special needs, particularly low income.
- MEDICARE
  - Part B coverage begins at 65 for medically necessary services.
- SELF-FUNDED
  - Employer contracts an insurance company to cover employees and dependents.

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ESSENTIAL HEALTH BENEFITS

as defined by the Affordable Care Act

HOSPITAL & EMERGENCY ROOM CARE

- Emergency Services
- Inpatient Care

MEDICATION & TESTS

- Prescription Drugs
- Laboratory Tests

NON-HOSPITAL CARE

- Ambulatory Care
- Pregnancy, Maternity, & Newborn Care
- Pediatric Services
  - Including Oral and Vision

SUPPORTIVE SERVICES

- Mental Health & Substance Abuse
- Services for Injury, Disability, or Chronic Conditions

PREVENTATIVE SERVICES

- Counseling, Screenings, Vaccinations

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QUALITY SERVICES & MEASURES

- Used by plans for Internal Control & External Review

ORGANIZATION	QUALITY MEASURE	SERVICES
National Committee for Quality Assurance (NCQA)	Healthcare Effectiveness Data and Information Set (HEDIS)	Asthma Medication Use, Breast Cancer Screening, Immunization Status
Utilization Review Accreditation Commission (URAC)	Health Plan Accreditation	Care Coordination, Medication Safety and Care Compliance
Pharmacy Quality Alliance (PQA)	Proportion of Days Covered (PDC)	Renin Angiotensin System Antagonists, Diabetes All Class, Statins

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RISKS

- **ADVERSE SELECTION**
- **MORAL HAZARD**
- SPECIALTY/HIGH COST MEDICATIONS
- FRAUD AND ABUSE
- MISDIAGNOSIS
- MARKET COMPETITION

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RISKS

- ADVERSE SELECTION:
  - Consumers most likely in need of health care are more likely to purchase insurance.
    - Higher Premiums
      - Drives away healthier consumers even more.

  - **Example: Premium- $400/month**
    - Healthy 25 y/o female: "If I remain uninsured, I'll probably spend less than $400 an entire year on health care."
    - 62 y/o obese diabetic woman with hypertension: "With $400 a month, most of my health care costs can be covered!"
    - Adverse Selection: 62 year old obese diabetic woman with hypertension enrolls.

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RISKS

- MORAL HAZARD
  - Consumers are less likely to avoid health risks if they have health insurance.
  - Increased use of health services because consumers aren't responsible for any/all of the costs.
  - Example: "I can eat fast food as I want because I have health insurance to cover medical costs that my diet may cause."

MANAGING RISKS

MANAGING ADVERSE SELECTION:

- SINGLE RISK POOLS
  - Insurance issuer combines all of its individual plans into one risk pool to calculate premiums for its members.
  - Higher costs of less healthy are covered by the lower costs of the healthy.

- RISK ADJUSTMENT
  - Transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees.
  - The individual risk score of the enrollee will help determine the plan's average actuarial risk.
    - Plans with lower actuarial risk will make payments to plans with higher risks.

MANAGING RISKS

MANAGING MORAL HAZARD

- HIGH DEDUCTBLES/COPAYS:
  - The more stakes a consumer has in his/her spending, the less likely they are to be wasteful.
  - Consumers will actively engage in their treatment and be interested in better value for their services.

- INCENTIVES
  - Insurance companies offer discounts on gym memberships and other wellness based savings.
  - Reduce risky behavior

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HOW ARE HEALTH PLANS FINANCED?

Health plans are financed through:

- UNDERWRITING INCOME:
  - Premiums collected – Expense for claim costs

If expenses exceed premiums collected:

- INVESTMENT INCOME
  - Financial Investments
    - Ex. Stocks, Real Estate, Banks
- INVESTORS

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FUTURE

- POPULATION HEALTH
  - Predicting a population's health through constant intervention
- RETAILABILITY
  - Walk-in medical facilities located in pharmacies, grocery stores, etc.
- MOBILITY
  - Mobile health apps
- GENETIC TESTING
  - Understand the human genome to make more tailored health choices
- PREVENTION
  - Electronic records inform treatment and reveal patterns in patient health

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SUMMARY

- A health plan is an insurance that covers all or part of your medical expenses.
- There are various quality measures to help compare health plans.
- Health plans have a risk for adverse selection and moral hazard.
- Some ways to prevent these risks is through risk-spreading and cost-sharing.
- The future of health plans may raise challenges for plans in managing expenses.

QUESTIONS?

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