Overview of Health Insurance & Managed Care Principles & History

Jonathan P. Weiner, Dr. P.H.
Professor or Health Policy & Management
Goals of Session

• To introduce some basic principles of health insurance and managed care.

• To provide a brief history and overview of health insurance and managed care in the US.

• To identify some key trends

Source: HCFA, CMS
# Paying for Health Care: Alternative Approaches

- Government employed providers
- Government “social insurance”
  - Mandatory buy-in
  - Entitlement for special populations
- As “benefit” of employment
  - Insurance
  - Direct care or access to contract providers
- Union/worker collectives
- Private “indemnity” health insurance
- Out of pocket
- Charity care
Definition of Insurance

• A social device where a group of persons transfers risk to an insuring entity in order to combine loss experience.

• This theoretically permits the ability to actuarially predict these “losses” and to calculate the premium payments that will need to be contributed by all members of the risk pool.
Some characteristics of an “ideal” private insurance market

- Large risk pool
- Predictable, but “random” event
- Potential high cost of insurable event
- Event not controllable by parties
  - “moral hazard”
- Market economically feasible
Approaches for Sharing and Bearing Insurance “Risk”

• Consumers
  – Premiums, cost sharing (deductibles, co-pays, co-insurance, coverage threshold)

• “Intermediary” (Insurance/managed care entity)
  – Inclusions/exclusions, thresholds, re-insurance

• Providers
  - Capitation, risk-sharing arrangements, employment

• Employers
  – Premiums, self-insurance, re-insurance
Patient Cost, Use, and Insurance Coverage

Why Employer’s Got Involved In Health Care

- Healthy employees are productive employees
- European immigrant / Union expectations
- Vacuum existed in the 1930-50’s, now “stuck” in this role.
- Tax advantage
- Attracts good employees
- “Self Insurance” (ERISA) is now big factor
US Health Insurance: Some Historical Footnotes

- 1930’s -- Blue-Cross/ Blue Shield and Hospital Association.
- 1930’s – Prepaid-Group Practices (PGPs) and Union/Employers
- 1950’s – Commercial insurers get into the act
- 1960’s -- Federal “great society” – Medicare and Medicaid
- 1970’s - The “Health Maintenance Organization” (HMO) Act (the unholy alliance of AMA sponsored IPAs and PGPs)
Proportion of Americans with Health Insurance: 1940-2005
## Health Care Financing and Coverage (Approx) in the US

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Ins.</td>
<td>67%</td>
<td>44%</td>
</tr>
<tr>
<td>Medicare</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Medicaid</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Uninsured</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>Out-of-Pocket</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>10</td>
</tr>
</tbody>
</table>
Who Pays for Health Care 1965-2001

CMS Office of the Actuary, National Health Statistics Group. Figures may not add due to rounding.
The “Actuarial Cycle” -- Cost / premium see-saw

Source: Salomon Smith Barney Research estimates based on data from CMS, Milliman USA, AAHP, and KPMG. As of February 27, 2003.
Insurance premiums vs. earnings and inflation

The Late 1980’s: medical inflation is out of control

- The bankrollers of the system said enough was enough, and the era of “managed care” was born. HMOs and their techniques served as the model.
Managed Care's Approximate Share of the Health Insurance Market in 1988 & 2007

- **1988:**
  - MCO: 75%
  - FFS: 25%

- **2007:**
  - MCO: 85%
  - FFS: 15%
The Key “Ingredients” of Managed Care

- Care “management”
  - aka, utilization/disease management

- Vertical integration / coordination

- Financial risk sharing with providers

- Attempts at instilling a market
Definition of Managed Care

An integrated system that manages health services for an enrolled population rather than simply providing or paying for them.

Services are usually delivered by providers who are under contract to, or employed by the plan.
The Health Insurance Models

- Traditional (Fee-for-Service) Indemnity
- “Managed” Indemnity Plan
- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
Shift in Employment-Based Plan Type 1988 - 2002

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002
Managed Care = US Health Care
• Health care cost spiral is inevitable.

• “We” consumers and providers want it “all.”

• Uninsured likely to grow, government not able (willing?) to tackle head-on.

• Other than MCOs, no party is willing (able?) to come to grips with resource limitations.