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Personal Finance Course

Health Insurance - HMOs

Guest Lecture by Robin Flagg

In this video, I'm going to talk about HMOs. And in particular, the outline for this talk, I'm going to tell you the history of HMOs, what is an HMO, how do a HMOs work, and what are the pros and what are the cons. And before I jump in, I just want to do a caveat here. I use HMOs, but they used to be called service plans early on when they were created. They became health maintenance organizations. They became managed care organizations. Now we call them health plans. And actually, in the ACA, which we'll be talking about, the Affordable Care Act, health care reform, which we'll be talking about in a later video, we're talking about something called accountable care organizations. And I suggest that those are actually HMOs as well.

So let's start off. What is the history of HMOs? Well, if you had seen my previous video where I talked about employer based coverage, employers pay for health care for employees and they get a tax break for this. But employers are spending a lot of money and they were looking for some less expensive options. And one of the options that came up was what we call a service plan. This started in the '30s. And a particular service plan that caught the attention of a lot of employers was Kaiser Health plan. And Kaiser Health plan was created to treat Kaiser employees on site by a doctor who was paid by Kaiser a monthly per person amount, $1.50 per person, to set up a clinic at a Kaiser site. This is how Kaiser started. The doctor who served Kaiser employees was there only for Kaiser employees, and Kaiser employees could only go to this doctor because he was already prepaid. So that's the concept in the history of it. You can look at my video on employer based coverage. I go into a little bit more of the history.

In the '80s, when health care became very expensive, employers were looking for some less expensive options. They had indemnity plans and they saw these service plans, and they looked at the two and service plans were deemed the winner. They were deemed the winner because A, employers knew how much each month they were able to pay. And they would gave it to the doctor or the health plan, if you will, Kaiser, and Kaiser would give it to the doctor. And the doctor would serve the patient. And if he served the patient well and kept the patient healthy, he would make money. If the patient got sick, he might lose money because it might cost more than he got per member per month. So the goal of the plan, the goal of the doctor was to keep the patient healthy. Hence, the name health maintenance organizations.

So in early 1980s, near nearly 90% of health plans were not for profit. By the end of 1988, more than 2/3 of them were for profit. Now the reason why I emphasize this is it changes how health plans worked. At this point, these health plans are trying to make a profit. So they get a per member per month from the employee. And they have that, and they are responsible for all the coverage. If the patient stays healthy, they can keep the money. If the person is sick, they have to pay for that care. Well, if they keep the money and therefore profit, and they have shareholders, they can give higher dividends. They can give money to their shareholders. So their goal was to not to give too much health care. To keep people healthy yes, but also to keep them from seeing the doctor a lot. So health plans put in what are called utilization controls. Utilization controls are just that. They're institutional mechanisms that try to control

utilization. So one that many of us are familiar with is what's called a gatekeeper. You have to go to a primary care, a lower pay doctor if you will, before you get permission to go to a higher pay doctor. This gatekeeper, this first doctor, this primary care doctor, is charged with helping the health plan save money and doing what that doctor can do and not to have you go to a specialist.

Another way that health plans save money is that they have a list of doctors, a network of doctors who are willing to accept an agreed upon premium. So they're willing to accept $10 per member per month, $50 per member per month. Whatever the rate is, and that is determined by actuaries and contract negotiations. Another mechanism that is using these utilization controls is called UR, utilization review. And what this is the health plan making sure that the care that's being provided is what the health plan believes is legit. So they have to give prior authorization. They have to give permission for you to go the dermatologist. They have to give permission for you to go to a specialist and so forth. You don't need permission to go to your primary care doctor, but you have to get prior authorization to go the next step.

Another utilization control is called concurrent review. So if you're in the hospital, the health plan, believe it or not as a nurse in the hospital often times, that is looking over the shoulder of the nurses and the doctors in the hospital, saying, I think this patient can go home. Another type of utilization control is where they profile physicians. They will send physicians a record of what they did that whole month. And they'll show how physicians rank against others. Nothing like peer pressure to make a doctor prescribe fewer antibiotics, right? And if a doctor has a lot of patients that go to the emergency room, that's not good and they don't want to be high on that list. There are also financial incentives that exist in utilization control, where doctors will get bonuses if they can keep their patients healthy and below a certain price target.

In fact, there's this company called PBMs, pharmacy benefit managers. They contract with HMOs. You may not even be aware that there's a separate company involved, but you might be. And these companies help negotiate drug prices for HMOs. But they in turn, then put controls on you to make sure that you don't take drugs that you don't need, which is good. But also, they want to make sure you use the least expensive drug that you could possibly use. So there are what we call tiered formularies.

A formulary is a list of drugs that you can use. And by law, an HMO or any insurance company for that matter, but an HMO must offer to you the formulary has to cover every diagnosis. So you have to have antibiotics, you have to have some painkillers, you have to have some cholesterol medicine, et cetera, et cetera. But there's different price ranges in those different diagnosis categories, and HMOs want you to use the cheapest. They want to save money because they keep what's left, but they also want to save money because it keeps the cost down. And remember, this is why employers picked HMOs to begin with. It was deemed add more cost effective than the old indemnity plan. But it's cheaper for you, and we'll talk more about cost sharing and how you start sharing the costs for health care with your employer.

Employers don't cover it all anymore. And that would make a difference. But the way they control these costs are by limiting choice. You have to go to a doctor in network. You can't just go to a specialist when you want. They determine it. So it's a trade off between choice and costs. What you do get from it, there's some good with HMOs, and a lot of people really enjoy that. The idea is there's the incentive of the health plan to help keep you healthy, to give you more primary care, to track what you're getting in

terms of services so you don't get too much, because too much isn't good, but also to make sure you get your vaccines and your preventative medicine. And they can capture all this information because you're in an HMO. So you have this trade off between choice and cost. We'll talk a lot more about cost in another video. Thanks.