Chapter 6: Financing and Reimbursement Methods

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Learning Objectives

At the end of this lecture, student should be able to:

- Explain why provider-induced demand is a moral hazard.
- Name and describe at least one of the parts of Medicare.
- Describe at least one reimbursement strategy used in insurance.
- Describe at least three efforts to increase health insurance coverage for children by way of public insurance.

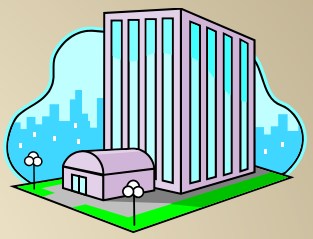
Effects of Health Care Financing and Insurance

Insurance: its nature and purpose

What is the Moral Hazard in the U.S. Health Care System?

Who finances? Taxpayers?

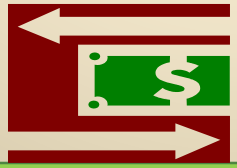
Financing



Insurance

Access to services

Moral hazard! Provider-induced demand!

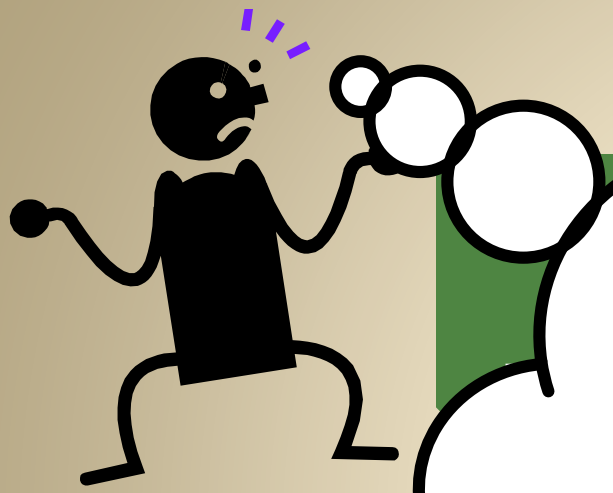


Payment to providers

Health Care Expenditures

From Figure 6.1 (page 131).

Health Care Financing and Its Effects



Total health care expenditures are greater than if the same services were to be paid by the patients!

Financing of health insura
(public/private) enables acce

From Exhibit 6.1 (page 131).

Basic Insurance Concepts

- *Risk:* Substantial financial loss from some event.
- *Insured/Enrollee/Beneficiary:* A person protected against this risk.
- *Underwriting:* The science behind risk.
- *Premium:* Amount charged each month for insurance coverage (can be paid by employer, insured, government, etc.)
- *Cost-sharing:* Ways the insured has to pay for the insurance (deductible, premium, copayment [$]/ coinsurance[%], but have stop-loss provisions)

4 Principles Underlying Insurance

- Risk is unpredictable for the individual insured.
- Risk can be predicted with a reasonable degree of accuracy for a group or population.
- Insurance provides a mechanism for transferring or shifting risk from the individual to the group through the pooling of resources.
- Actual losses are shared on some equitable basis by all members of the insured group.

Isn't an entire country one of the biggest groups you can have?

Affordable Care Act

- Individuals required to have insurance or pay tax penalties
- Employers of >50 employees must offer insurance or pay "free rider" tax
- Medicaid expanded to cover very poor, and subsidize less poor
- States mandated to set up insurance exchanges so individuals can afford insurance
- Sliding-scale tax credit allowed for businesses <25 employees
- Illegal to deny benefits to those with pre-existing conditions

From page 147.

Will these changes work?

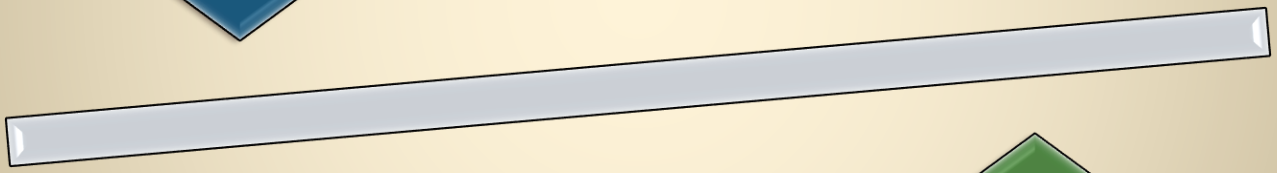
Private Insurance

Private Health Insurance

- "Voluntary health insurance" – not mandatory
- Mostly employer-based (through workplace)
- Many different health plan providers: commercial insurance companies (Aetna, Met Life, Prudential), non-profit BC/BS, self-insured, MCOs
- Self vs. family plans (different from public insurance, where each is own beneficiary)
- 79% of workers eligible, but only 65% take coverage
  - Reasons not to 1) already under spouse's coverage, 2) low wage, 3) young age
- Cost of employer-based insurance varies widely from workplace to workplace

Employer Characteristics Associated with Health Insurance Rates

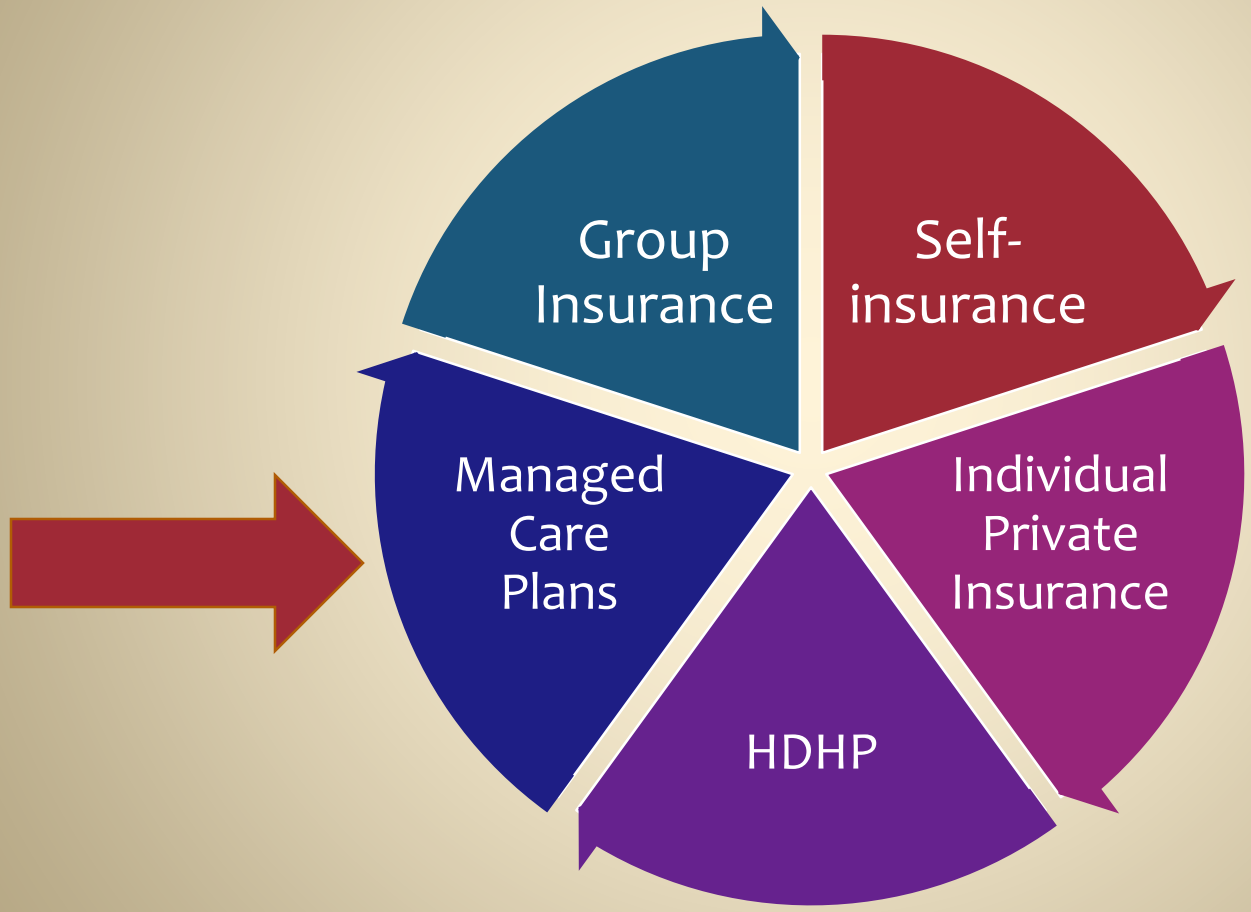
- Large employers
- Greater number of high wage earners
- More full-time workers
- Nonunionized employers
- Higher proportion of younger workers



- Small employers
- Greater number of low wage earners
- More part-time workers
- Unionized employers
- Higher proportion of older workers

From Exhibit 6.2 (page 136).

Five Types of Private Insurance



Types of Private Insurance

Group Insurance	• Obtained through emp., union, professional org. • "Major medical plan" - catastrophic
Self-insurance	• Employer large enough to offer its own insurance • Employer pays employee's health claims
Individual Private Insurance	• Farmers, early retirees, self-employed • High risk people not eligible
High-deductible Health Plans	• High deductible, but can save in HSA or use HRA and save money

Managed Care Plans

- In 2011, 90% of employer-based health plans were managed care plans.
  - 17% of employer-based coverage was through HDHP
  - By contrast, 5% of Americans covered under Individual Private Insurance (most likely not working)
- We know about MCOs
  - Health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
  - Contract with network of providers, reimbursement, monitor utilization

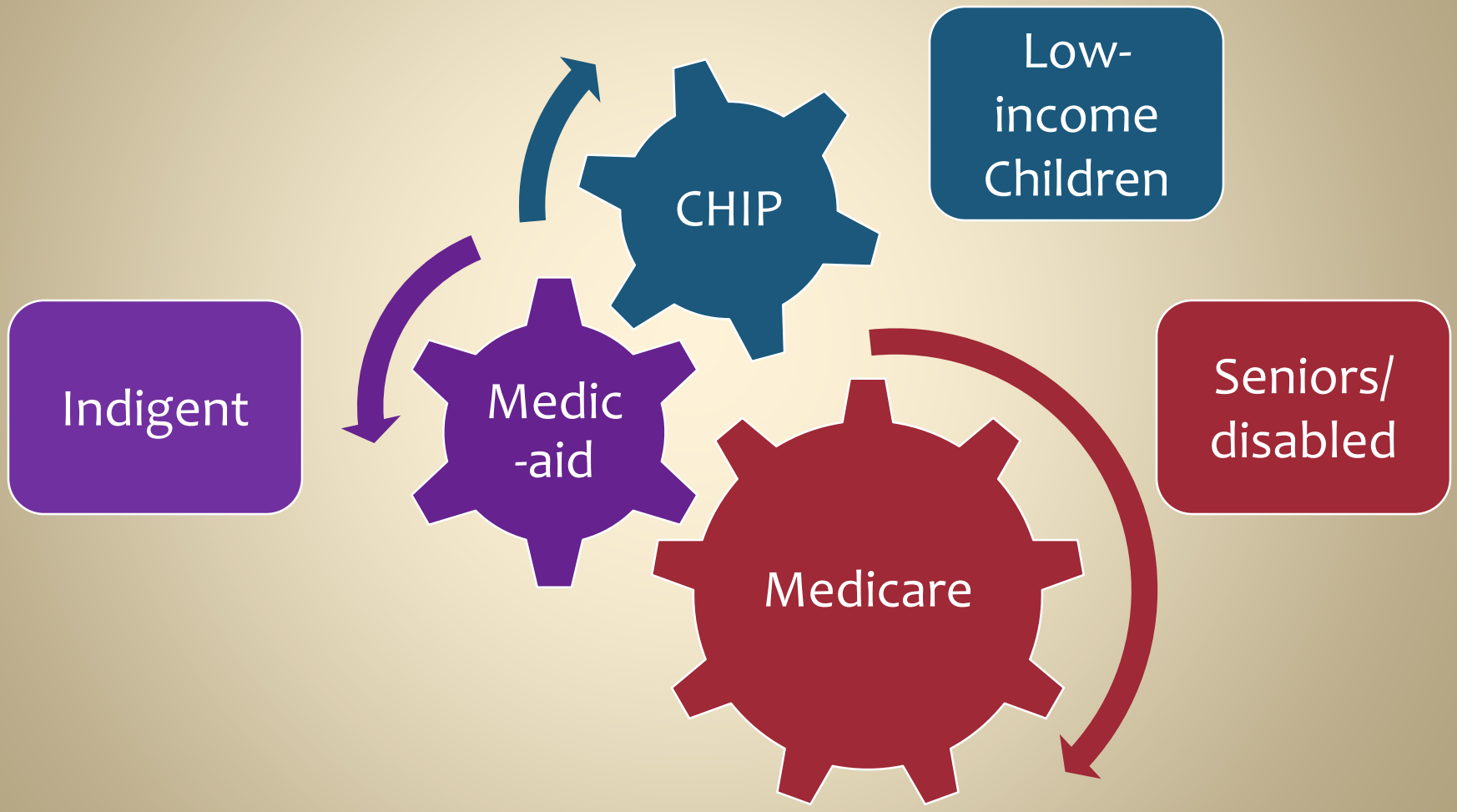
Public Insurance

Medicare, Medicaid, CHIP

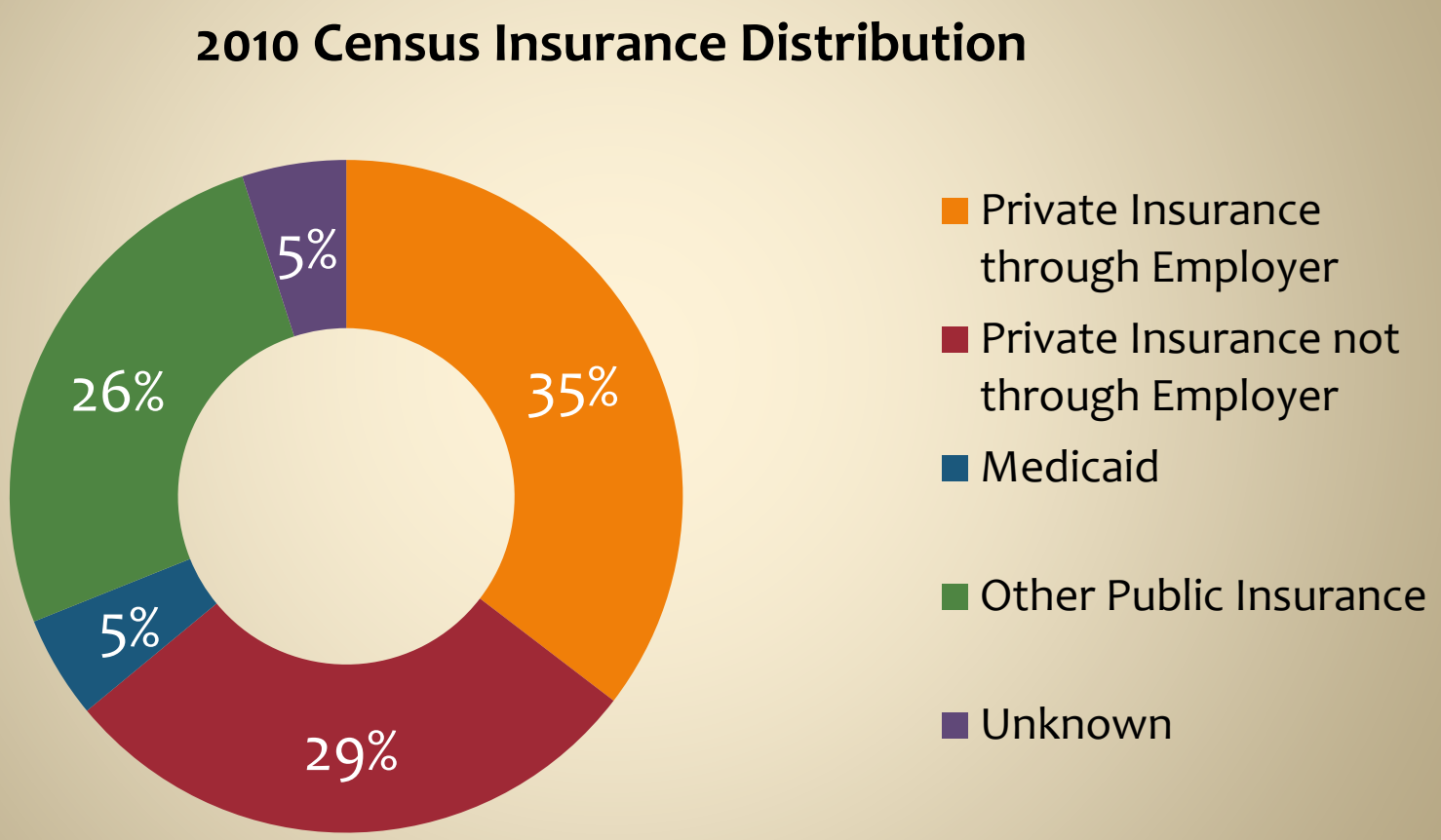
Major Public Health Insurance Programs

- "Public insurance" is insurance funded by the government where services are purchased from the private sector (for the most part) – exception is VA
- Public financing supports "categorical programs" (through which people are put on public insurance)
  - Persons in the "category" get the insurance (e.g., Age 65+ get Medicare)
  - No program specifically for unemployed

Medicare, Medicaid, and CHIP



Public vs. Private Insurance

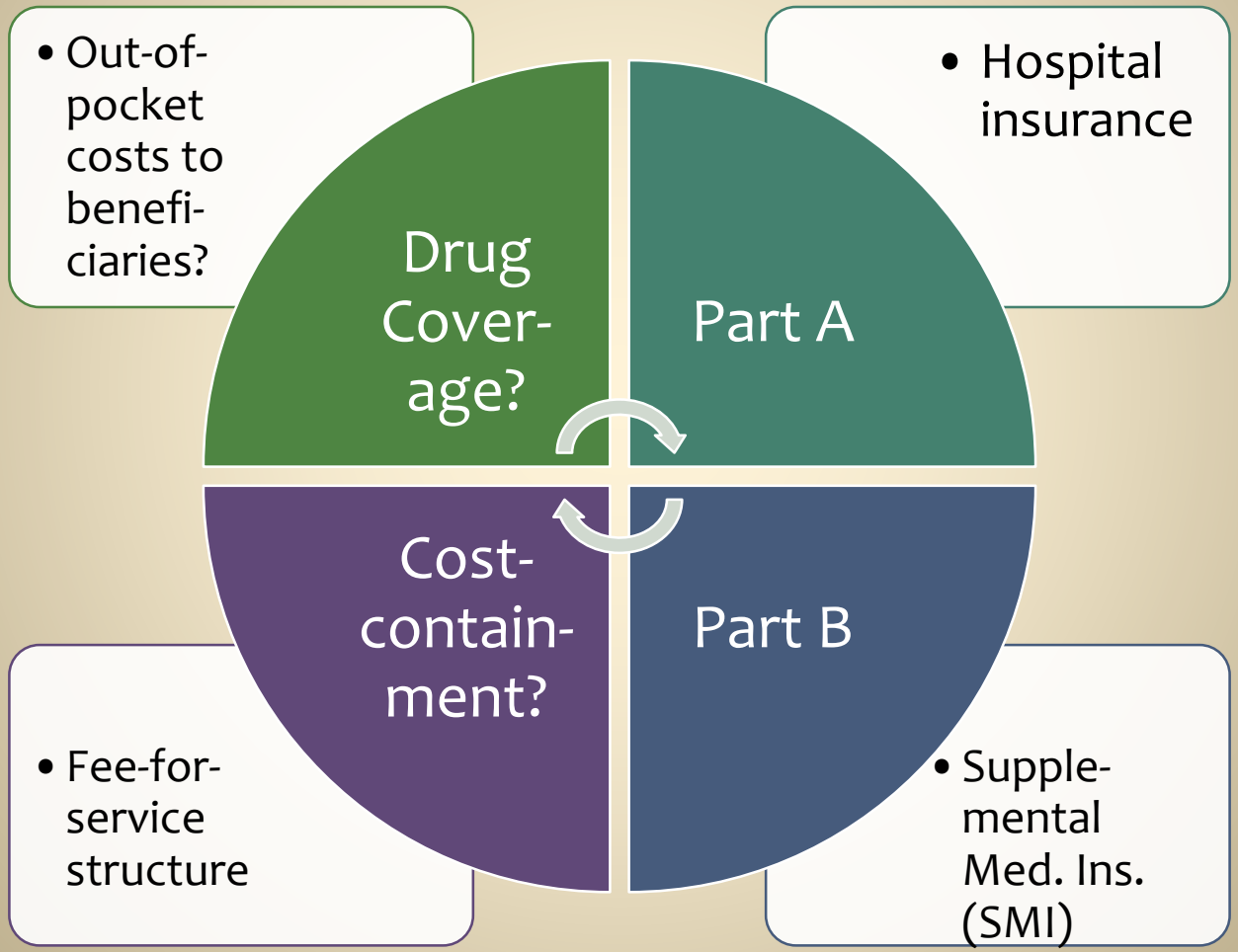


From page 138.

Medicare

Title 18 of the Social Security Act

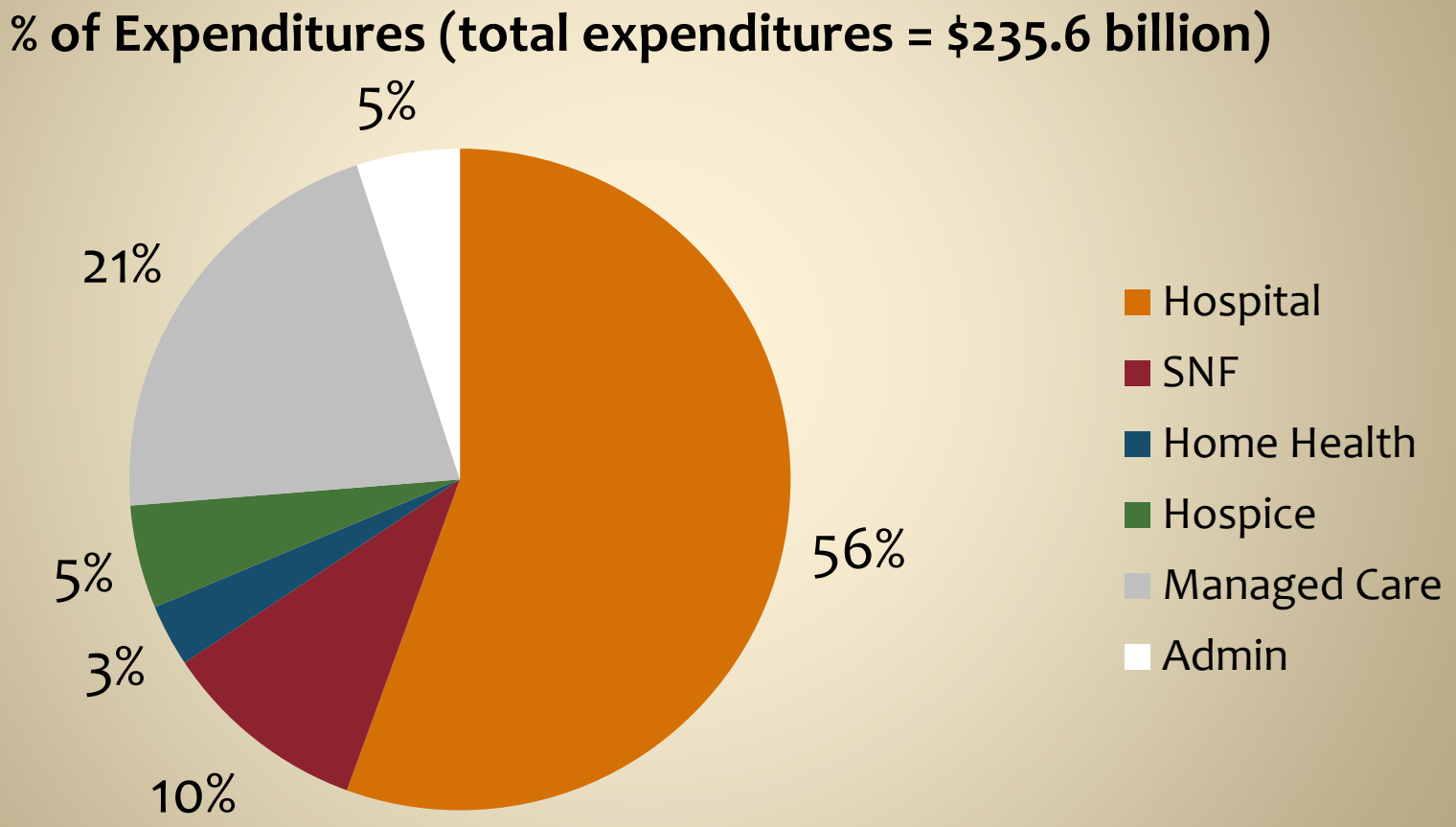
Medicare 1966-1997



Medicare Part A

- Hospital insurance – financed by "Medicare Tax"
- Pays for hospitalization, rehab in Skilled Nursing Facility (SNF), home health care, and for terminally ill, hospice.
- Rules are complicated
  - "Benefit period" – period of time after initial admission that the patient will get benefits for that admission
  - Hospital benefit period – after 60 days, patient pays copayment of $289 per day (2012).
- Medicare must certify agencies providing the services (e.g. home health care)

Medicare Part A Expenditures – 2008 Estimates

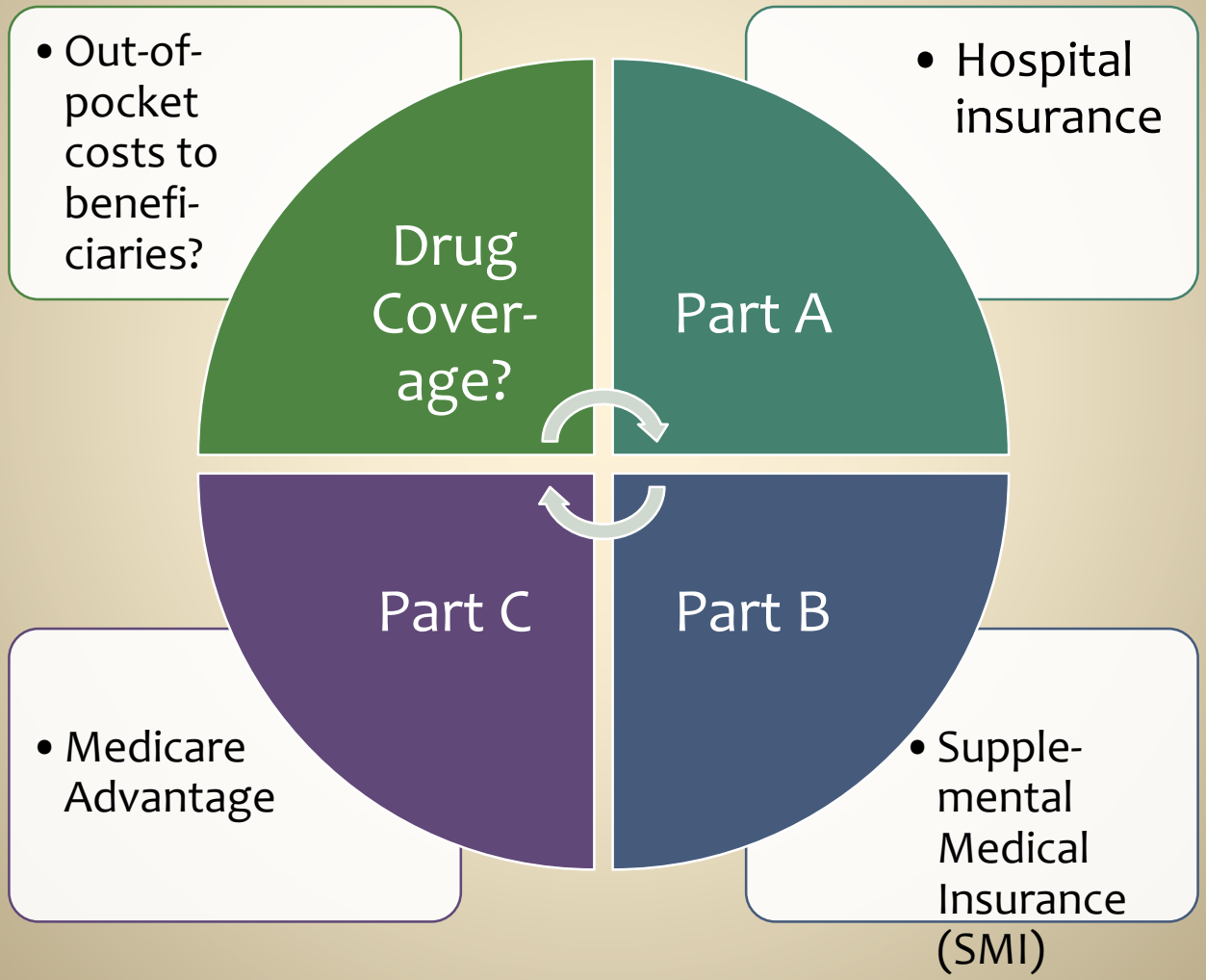


From Figure 6.2, Page 141.

Medicare Part B

- Supplementary medical insurance (SMI) – also known as Medigap insurance – covers the "gap" between hospitalization and necessary outpatient services
- Medicare Part A recipients can opt into B, and usually do, because there is little competing in the price range
- "Supplementary" to A: Covers following services: physician, ambulance, outpatient rehab, some preventive services, but mainly outpatient hospital services (outpatient surgery, diagnostics, etc.)
- *Why do you think Part A and Part B go together? Do you think the importance of Part B has grown over the years? Why?*

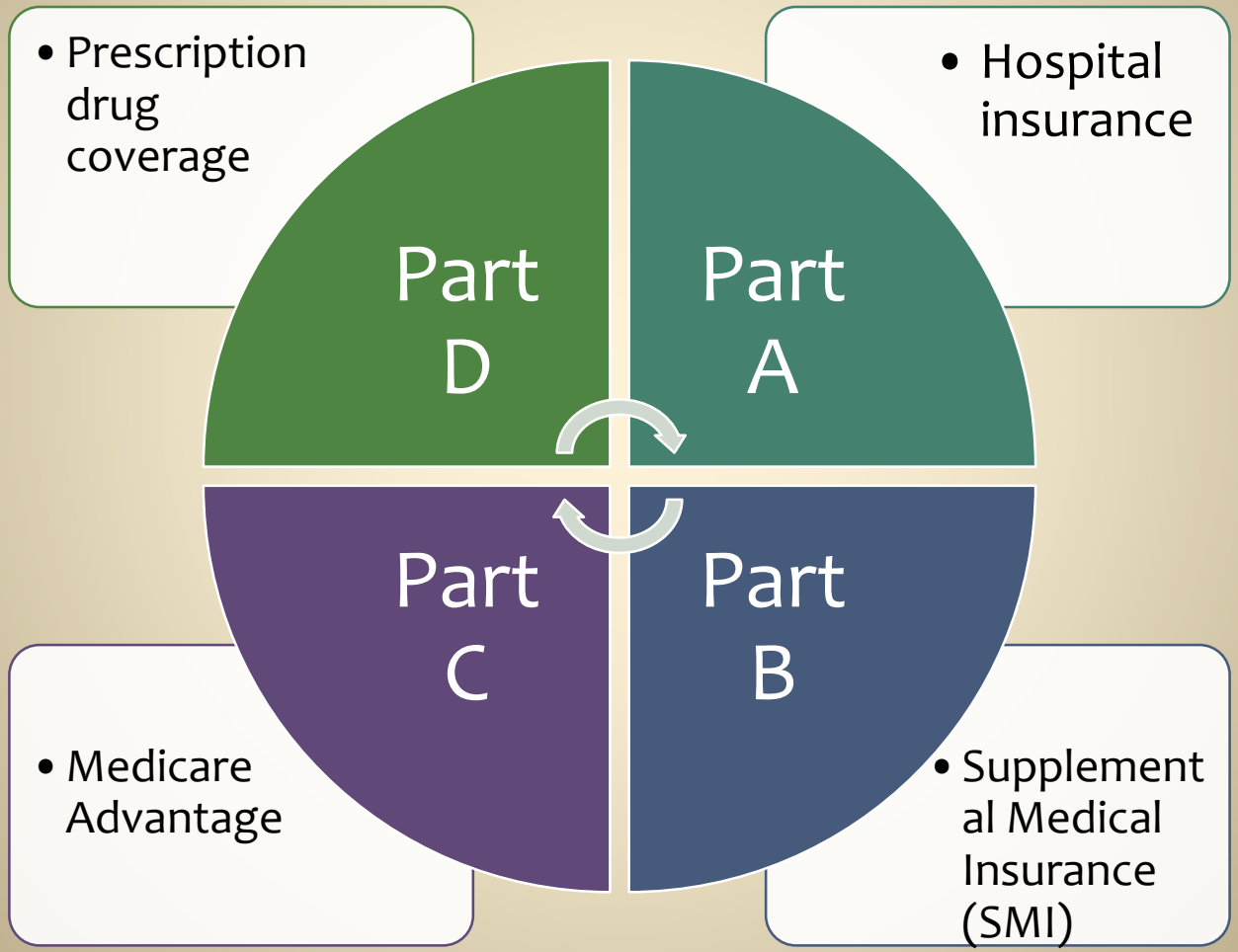
Medicare <2003/2006



1997 – Medicare Part C

- Not really a "program" that covers any particular services
- Response to calls for "privatization" for governmental services in the '90s
- Mandated by the Balanced Budget Act of 1997
- Basically, patient could choose old-fashioned Medicare, or Medicare+Choice
  - Old-fashioned: Medicare-approved facilities, fee-for-service
  - Medicare+Choice: Choose an HMO or PPO plan (MCO)
- 2003 – now Medicare+Choice called MMA, revamped to keep MCO's from withdrawing, other issues

Medicare Today



2003-2006 – Medicare Part D

- Even with Part C coming on board in 1997, drugs still an issue – one that could be handled with MCO
- Part D added in 2003 and implemented in 2006
- Created two types of private plans:
  - PDPs – offers only drug coverage, and only available to old-fashioned fee-for-service Medicare
  - MA-PDs – When signing up for Part C, this comes as part D, and the patient gets drugs through MMA
- Take-home message
  - All the pressures are toward new Medicare enrollees signing up for Part C to get their Parts A, B, C, and D dealt with all through an MCO
  - *Why?*

Medicare Part C upgrade in 2003

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  plan – less choice

MMA

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- from MA-PDs

I want to know which of these will save me the most money!

How does this work for the beneficiary?

re I

How does this work for the drug companies?

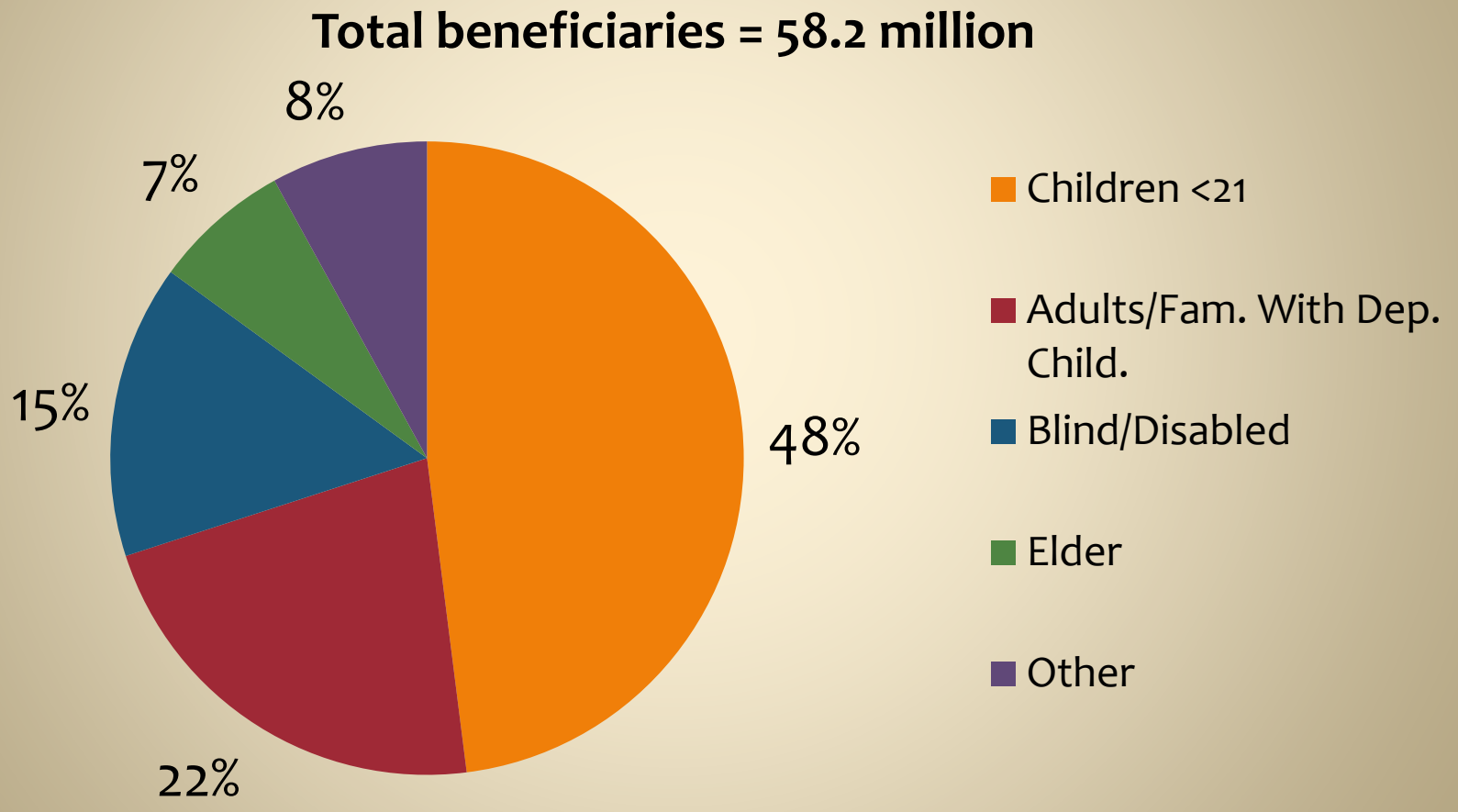
Deductible	Initial Coverage	Gap or "doughnut hole"	Catastrophic Coverage
• For drug costs up to $320 in the year • Beneficiary pays 100%	• For drug costs $321 - $2,930 in the year • Medicare pays 75% (up to $1,957.50) • Beneficiary pays up to $652.50 (25%)	• For drug costs 2,931-$6,657.50 in the year • Beneficiary pays 100% up to $3,727.50 (up to 50% discount on drugs)	• For drug costs over $6,657.50 in the year • Beneficiary pays about 5% • Medicare pays 95%

From Table 6.1 on page 144

Medicaid

U.S. Public Health Insurance Program for the Indigent

Medicaid Recipient Categories, 2008



From Figure 6.3 on page 145.

More on Medicaid

- Title 19 of the Social Security Act
- Each state has its own eligibility criteria (e.g. for being indigent – finances, etc.)
  - Federal law requires coverage for low-income elders, blind, disabled (receiving SSI), some pregnant women.
  - Lots of coverage to children in low-income families.
  - Most states defined other "medically needy" categories and support them (populations in institutions, those getting outpatient services so they don't have to live in institutions, etc.)
- Dramatic variations state to state. Wealthier states have smaller share of cost reimbursed by federal government.

Select Federally Mandated Services for [redacted]edicaid Programs

Role for nursing?

- [redacted]acility svcs. for age 21+
- [redacted]ealth svcs. for those who qu[redacted]ify for a
- Certified ped. and f[redacted] (state-licen[redacted]

- Nurse mid-wife[redacted]

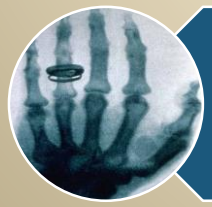
From Table 6.2 on page 146

Select Federally Mandated Services for State Medicaid Programs

Inpatient hospital services

Outpatient hospital services

Rural health clinic services



Outpatient laboratory and x-ray services

From Table 6.2 on page 146

Children's Health Insurance Program

CHIP

CHIP

- Title 21 of the Social Security Act
  - Enacted under the Balanced Budget Act of 1997
- Originally for 10 years, now even Affordable Care Act (ACA) extended through 2015
- At the time, about 25% of low-income kids uninsured
- Federal matching dollars to states who expanded Medicaid to cover kids (<19), certain adults (pregnant women, parents/caretakers)
  - Can set up non-Medicaid program, or a hybrid of the two, as well, and get the match
- December 2010 – 5.2 million kids enrolled in CHIP

Reimbursement Methods

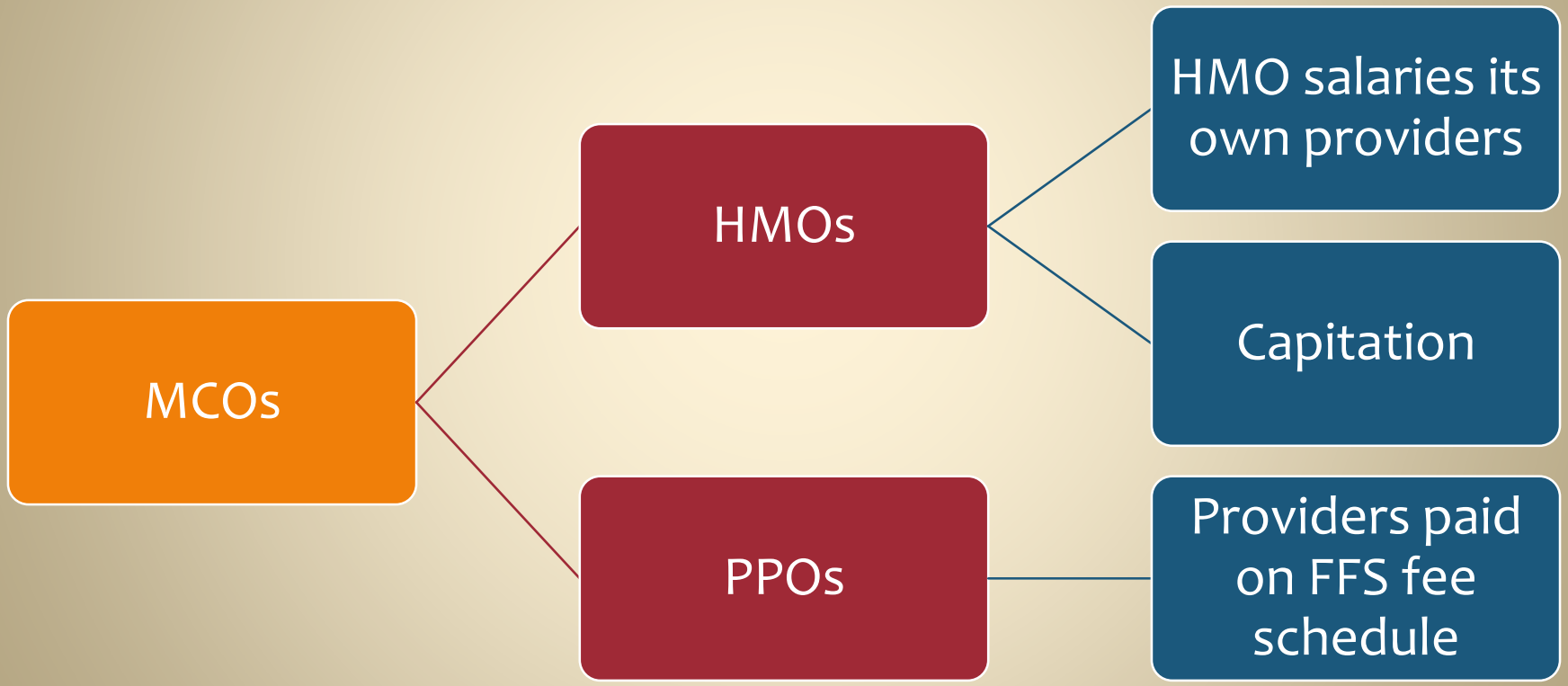
Fee-for-service and Package Pricing

- Fee-for-service
  - Just do the service, and charge by the unit. If the child falls out of the tree, charge for x-ray, cast, etc.
  - Common before 1990s. Some cases, insurance limited reimbursement and beneficiary had to pay balance.
  - Main problem with fee-for service – providers induce demand = non-essential care.
- Package pricing or "bundled charges"
  - May figure out, on average, how much a bundle of charges would be (e.g., vaginal delivery services).
  - Package deal at optometrist: eye exam + glasses

Procedure-based Reimbursement

- 1989 – Medicare invents the "resource-based relative value scale" (RBRVS)
  - Complex reimbursement formula involving time, skill, and intensity it takes to perform a service
- Procedure code classification – CPT code
- Medicare publishes yearly fee schedule for reimbursement by CPT code based on RBRVS of the CPT
- Non-public insurances follow suit

Reimbursement Under Managed Care



Retrospective and Prospective Reimbursement

RETROSPECTIVE

- <1983 for hospitals, <1997 for hosp. outpt./SNFs, home health, rehab
  - "per diem" rates – overnight stays
  - Per diem rates set by calculating previous year's actual cost at facility for services
- Facilities could increase their rates by increasing their costs – "perverse"

PROSPECTIVE

- More recent – part of budget-cutting/cost containment
- Pre-established criteria used to determine amount of reimbursement in advance
- Prospective reimbursement methods: DRGs, APCs, RUGs, HHRGs

Prospective Reimbursement Strategies

- Dx-related groups - inpt
- N=500
- Fixed price, but based on factors (rural)

DRGs

APCs

- Like DRGs, but for ambulatory
- N=300
- Also fixed price based on factors

- Similar, but for SNFs
- N=66
- Classifies patient character-istics "case mix"

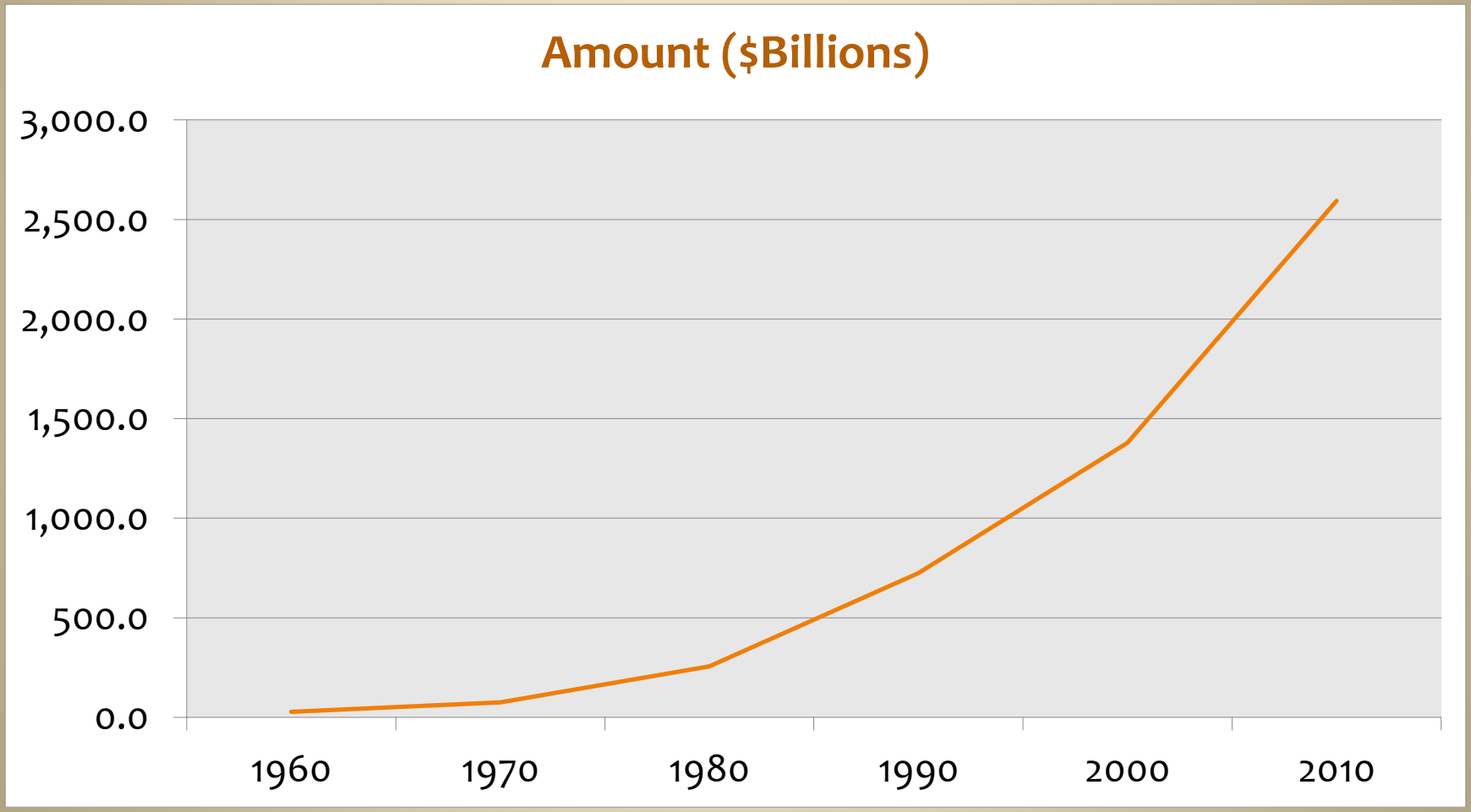
RUGs

HHRGs

- Similar, but for home health
- N=153
- Uses OASIS calculation

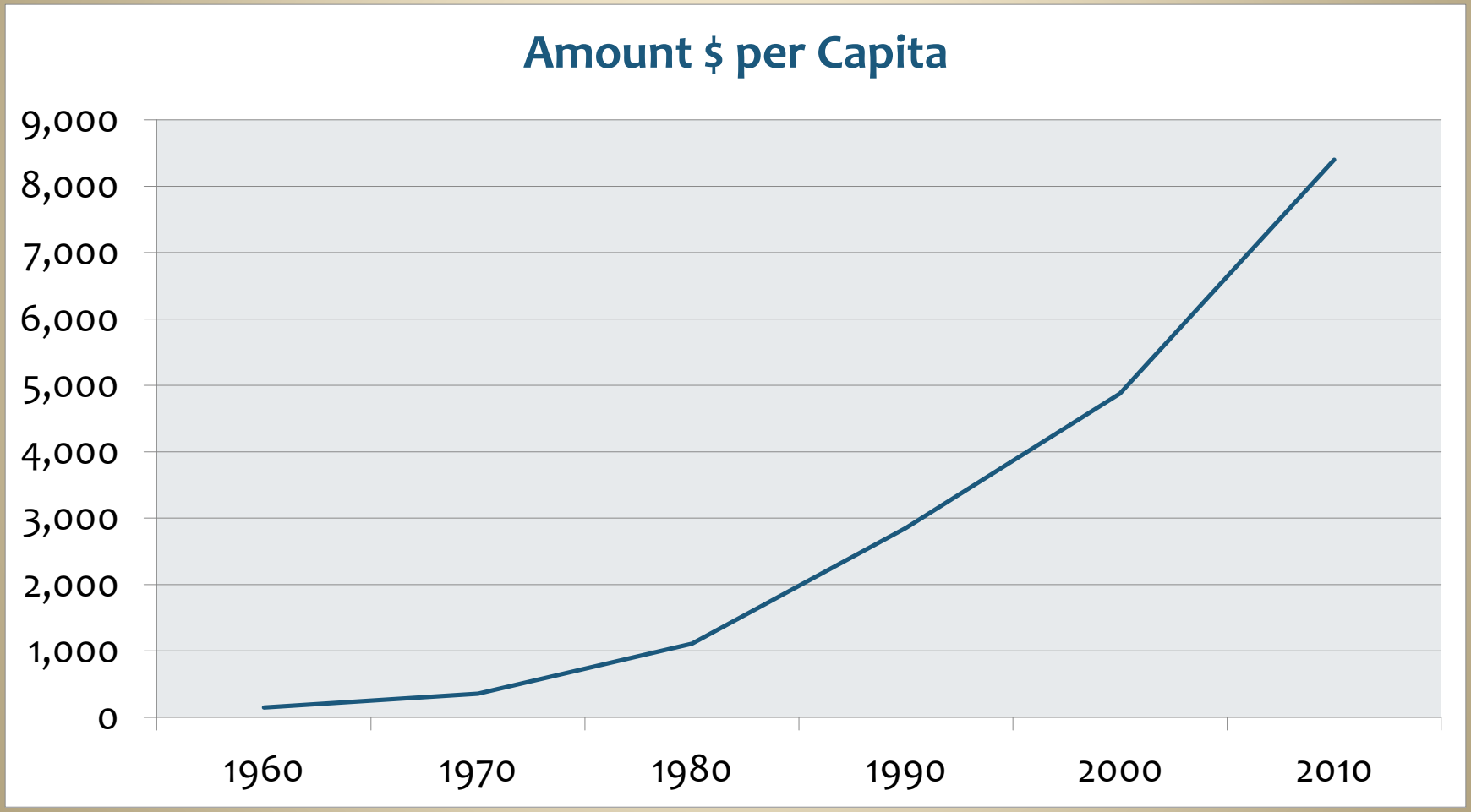
National Health Expenditures

National Health Expenditures, Selected Years



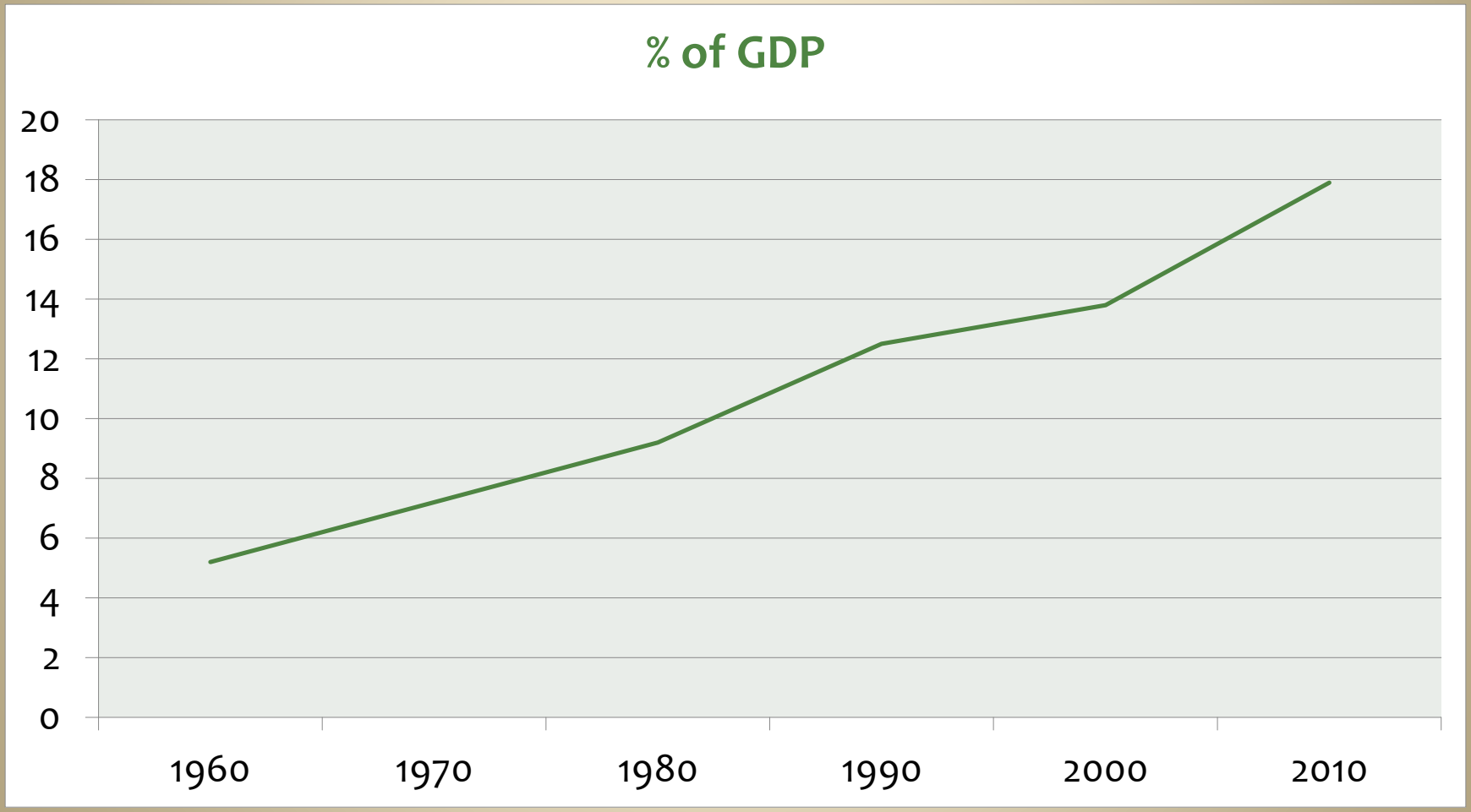
From Table 6.4 on page 153.

National Health Expenditures, Selected Years



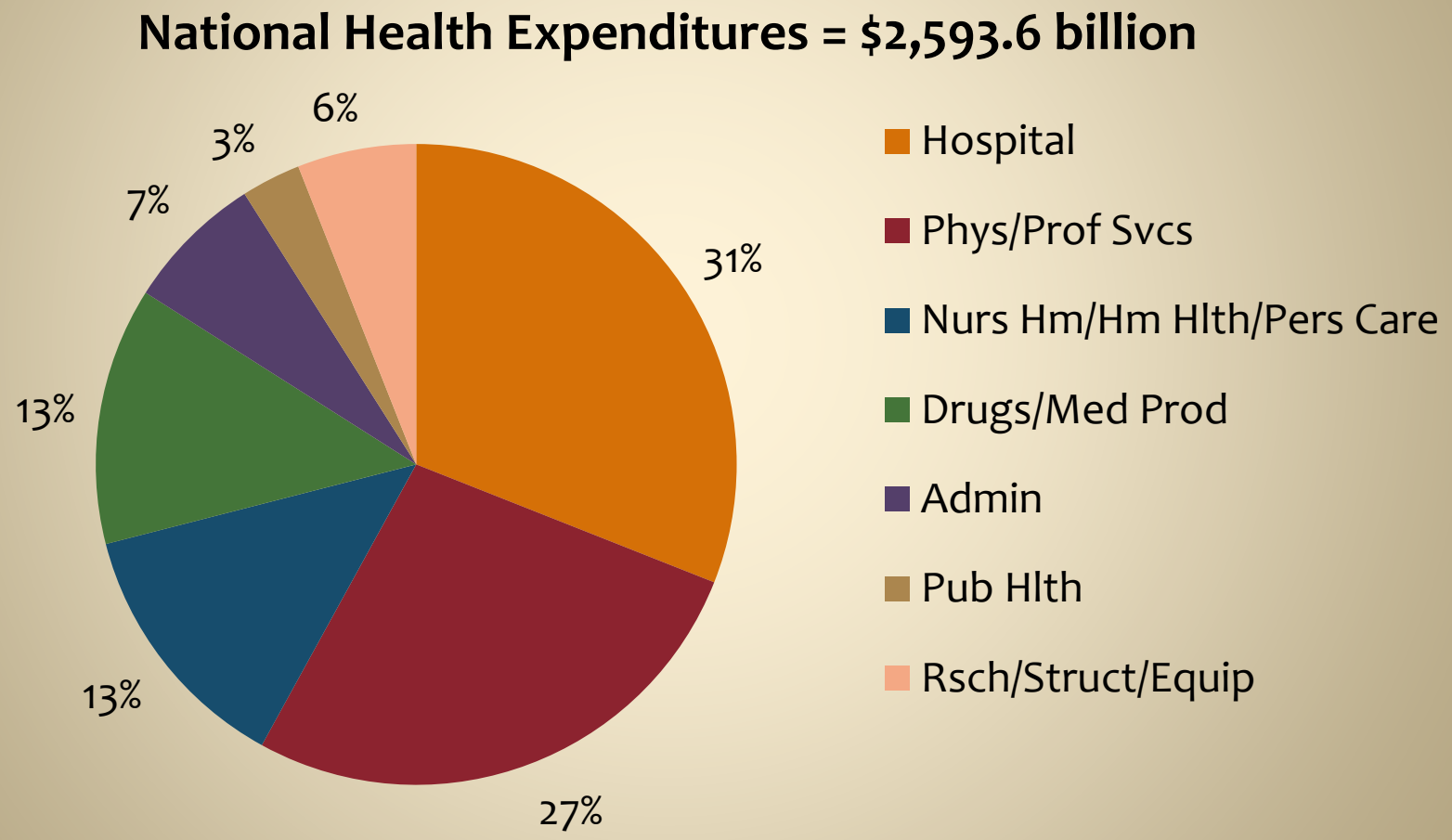
From Table 6.4 on page 153.

National Health Expenditures, Selected Years



From Table 6.4 on page 153.

Breakdown of National Health Expenditures, 2010



From Figure 6.4 on page 154.

Conclusion

- Although there are different insurance structures, most are now using MCOs
- Although there are different ways to get insurance, those on private insurance usually get it through an employer
- A lot of people are on public insurance, mostly seniors (Medicare) and children (Medicaid, CHIP)
- Public insurance mostly uses MCOs to contain costs
- Nevertheless, public or private, insurance and health care cost is going up in the U.S.

Learning Objectives

At the end of this lecture, student should be able to:

- Explain why provider-induced demand is a moral hazard.
- Name and describe at least one of the parts of Medicare.
- Describe at least one reimbursement strategy used in insurance.
- Describe at least three efforts to increase health insurance coverage for children by way of public insurance.