STUDENT ACTIVITY 6-4

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Organization Name: _____

Mission Statement:

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Overview of Activities:

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Importance of organization to US health care:

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Organization Name: _____

Mission Statement:

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Overview of Activities:

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Importance of organization to US health care:

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Chapter 7

Private and Public Financing of Health Care

LEARNING OBJECTIVES

The student will be able to:

- Discuss the different cost-sharing strategies in health insurance plans.
- Analyze the different types of consumer-driven health plans.
- Discuss the importance of Medicare and Medicaid to health care.
- Identify the different government and private health insurance reimbursement methods.
- Evaluate the different types of health insurance policies.
- Describe PACE, TRICARE, and SCHIP and their importance to health care.

DID YOU KNOW THAT?

- Nearly 60% of Medicare enrollees are female, which corresponds to the longer life expectancy of a US female.
- The state of Massachusetts has the highest per capita of personal healthcare spending at nearly $7000.
- Medicare and Medicaid are the two largest government-sponsored health insurance programs in the United States.
- A lifetime cap of $1,000,000 reimbursement of an enrollee's health services may be established by a private health insurance company.
- Approximately 84% of the US population is covered by some form of health insurance.

INTRODUCTION

As mentioned in several chapters, the percentage of the US gross domestic product (GDP) devoted to healthcare expenditures has increased over the past several decades. The Centers for Medicare and Medicaid Services (CMS) projects that health services will consume nearly 20% of the GDP by 2016. According to CMS 2007 statistics, US healthcare expenditures increased 6.1% compared to 6.7% in 2006. Total health expenditures reached $2.2 trillion, which translates to 16.2% of GDP (CMS, 2009a). Since 1970, healthcare spending has grown 2.5% faster than the rest of the US economy. The increase in healthcare spending can be attributed to three causes: (1) When prices increase in an economy overall, the cost of medical care will increase and, even when prices are adjusted for inflation, medical prices have increased; (2) as life expectancy increases in the United States, more individuals will require more medical care, which means there will be more healthcare expenses; and (3) as healthcare technology and research provide for more sophisticated and

more expensive procedures, there will be an increase in healthcare expenses (Pointer, Williams, Isaacs, & Knickman, 2007).

There are four areas that account for a large percentage of national healthcare expenditures: hospital care, physician and clinical services, prescription drugs, and nursing and home healthcare expenditures (Longest & Darr, 2008). Unlike countries that have universal healthcare systems, payment of healthcare services in the United States is derived from (1) out-of-pocket payments from patients who pay entirely or partially for services rendered; (2) health insurance plans, such as indemnity plans or managed care organizations; (3) public/government funding such as Medicare, Medicaid, and other government programs; and (4) health savings accounts (HSAs) (Buchbinder & Shanks, 2007; Shi & Singh, 2008; Sultz & Young, 2006). Much of the burden of healthcare expenditures has been borne by private sources—employers and their health insurance programs have borne much of the cost. In 2007, approximately 60% of Americans (180 million) had private health insurance coverage (Davis, 2007). The number of uninsured in the United States has been approximately 47 million; however, with the dramatic increase in unemployed during 2008 and 2009, it is anticipated that the number of uninsured will dramatically increase because they no longer have a relationship with their employer who has provided a large portion of health insurance coverage. Individuals may continue to pay their health insurance premiums through the Consolidated Omnibus Budget Reconciliation Act (COBRA) once they are unemployed but most individuals cannot afford to pay the expensive premiums. Potentially, the government may play a larger role in providing health care. President Barack Obama has named healthcare reform a priority of his administration. There are several healthcare reform bills in the legislature proposed by both political parties that focus on providing affordable health care to more individuals. However, there are major differences on how to implement a policy. It will be interesting to see what type of initiative will be developed to increase the number of individuals who will be able to receive health care.

To understand the complexity of the US healthcare system, this chapter will provide a breakdown of the US healthcare spending by type, age, and state and the major private and public sources of funding for these expenditures. It is important to reemphasize that there are three parties involved in providing health care: the provider, the patient, and the fiscal intermediary such as a health insurance company or the government. Therefore, included in the chapter is also a description of how healthcare providers are reimbursed for their services and how reimbursement rates were developed for both private and public funds.

HEALTHCARE SPENDING BY SERVICE TYPE

In 2007, hospital spending was nearly $700 billion, physician and clinical services was $480 billion, and other professional services such as chiropractors, optometrists, and podiatrists was $62 billion. Dental services were $95 billion and community center and school spending was $66 billion. Home healthcare services were $59 billion, an increase of 11% from 2006. Nursing home spending was $131 billion, prescriptions drug spending was $227 billion, and medical equipment was $61 billion (CMS, 2009a). Hospital spending accounted for the largest percentage of national healthcare expenditures with physician and other services, prescription drugs, and nursing and home health the next three largest.

HEALTHCARE SPENDING BY MAJOR SOURCES OF FUNDS

In 2007, Medicare spending was $431 billion, which was an increase of 7.2% from 2006. Medicaid spending was $329 billion, which was a slight decrease from 2006. Private health insurance premiums grew 6% while benefit payments decreased because of a decline in spending on prescription drugs. Out-of-pocket payments grew 5% in 2007, which was a result of prescription drugs costs, nursing home services, and medical equipment. Out-of-pocket spending accounted for 12% of national health spending in 2007 and has declined over the past 10 years (CMS, 2009a).

HEALTHCARE SPENDING BY AGE AND GENDER

In 2004, spending per persons 65 years and older was $8644; $1245 for children younger than 5 years of age; $1108 for children between 5 and 17 years of age; $1282 for 18 to 24 years of age; and $2277 for 25 to 44 years of age. Average spending for females was $3715 and $2836 for males (Kaiser Family Foundation [KFF], 2007). These numbers correlate with the fact that the longer we age, the more chronic conditions occur that

result in higher spending and female life expectancy is longer than male life expectancy.

HEALTHCARE SPENDING BY STATE

In 2004, the state of Massachusetts' per capita of personal healthcare spending was $6683 compared to a low of $3972 in Utah. The highest per capita spending was in Massachusetts, Maine, New York, Alaska, and Connecticut. The lowest per capita spending was in Utah, Arizona, Idaho, New Mexico, and Nevada. Medicare expenditures per beneficiary were the highest in Louisiana ($8659) and lowest in South Dakota ($5640). Medicaid expenditures per enrollee were the highest in Alaska ($10,417) and lowest in California ($3664). California's total personal healthcare spending was the highest at 10.8% with the lowest in Wyoming at 0.1%. All states except Delaware and Wyoming spent at least 10% or greater of GDP (CMS, 2009a).

HEALTH INSURANCE AS A PAYER FOR HEALTHCARE SERVICES

Like life insurance or homeowner's insurance, **health insurance** was developed to provide protection should a covered individual experience an event that required health care. In 1847, a Boston insurance company offered sickness insurance to consumers. During the 19th century, large employers such as coal mining and railroad companies offered medical services to their employees by providing company doctors. Fees were taken from their pay to cover the service. In 1913, a union-provided health insurance was provided by the International Ladies Garment Workers where health insurance was negotiated as part of their employment contract. During this period, there were several proposals for a national health insurance program but the efforts failed. The American Medical Association (AMA) was worried that any national health insurance would impact the financial security of their providers. The AMA persuaded the federal government to support private insurance efforts. Employer-based health insurance grew rapidly post–World War II for three decades with some stability for one decade and an eventual decline in coverage since the late 1980s (Enthoven & Fuchs, 2006). However it is still the major method of providing health care in the United States.

In 1929, a group hospital insurance plan was offered to teachers at a hospital in Texas. This became the foundation of the nonprofit Blue Cross Blue Shield (BCBS) plans. In order to placate the AMA, BCBS initially offered only hospital insurance in order to avoid infringement of physicians' incomes (BCBS, 2009; Starr, 1982). In 1935, the Social Security Act was created and was considered "old age" insurance. During this period, there was continued discussion of a national health insurance program. But with the impact of World War II and the Depression, there was no funding for this program. The government felt that the Social Security Act was a sufficient program to protect consumers. These events were a catalyst for the development of a health insurance program that included private participation. Although a universal health coverage program was proposed during President Clinton's administration in the 1990s, it was never passed. In 2005, Massachusetts proposed mandatory health coverage for all citizens so it may be that universal health coverage may begin at the state level (KFF, 2007). As stated previously, the Obama administration has placed a high priority on healthcare reform, which could include some type of increase in healthcare coverage.

In the 1960s, President Johnson signed Medicare and Medicaid into law which protects the elderly, disabled, and indigent. President Nixon signed into law the Health Maintenance Act of 1973, which focused on effective cost measures for health delivery and was the basis for the current health maintenance organizations (HMOs). Also, in the 1980s, diagnosis-related groups (DRGs) and prospective payment guidelines were established to provide guidelines for treatment. These DRGs were attached to appropriate insurance reimbursement categories for treatment. Also, in the 1980s and 1990s, several consumer laws were passed. COBRA was passed to provide health insurance protection if an individual changes jobs. In 1993, the Family and Medical Leave Act (FMLA) was passed to protect an employee in the event of a family illness. Employees can receive up to 12 weeks of unpaid leave and their health insurance during this period. Also, in 1996, the Health Insurance Portability and Accountability Act (HIPAA) was passed which provided stricter confidentiality regarding the health information of individuals.

TYPES OF HEALTH INSURANCE

Health insurance, particularly employer-provided health insurance, is the primary source of payment of healthcare services in the United States. Unfortunately, employers providing health insurance has become very expensive for businesses. Administrative costs

are estimated at $120 billion annually. There are approximately 850 health insurance companies that contract with millions of employers to provide coverage (Emanuel, 2008). There are four types of private insurance: group insurance, individual private health insurance, self-insurance, and managed care plans. **Group insurance** anticipates that a large group of individuals will purchase insurance through their employer and the risk is spread among those paying individuals. If an individual is self-employed, such as small business owner or farmer, they may purchase **individual private health insurance**. Unlike group insurance, the risk is determined by the individual's health. Premiums, deductibles, and copayments are much higher for this type of insurance. Established in the 1970s, **self-funded** or **self-insurance** programs are health insurance programs that are implemented and controlled by the company itself. **Managed care plans** are a type of health program that combines administrative costs and service costs for cost control.

Most group health insurance is provided by employers to their employees (Pointer et al., 2007). Health insurance is a financing mechanism that protects the insured from using their personal funds when expensive care is required. Having insurance also decreases the risks of delays in seeking treatment that may result in costly delays and increased disease (Sultz & Young, 2006). Approximately 84% of the population is covered by some form of health insurance. All insurance plans fall into three categories: voluntary health insurance (VHI), social insurance, and public welfare insurance. **VHI** is a type of private health insurance that is provided by nonprofit and for-profit health plans such as BCBS. **Social insurance** is provided by the government at all levels: federal, state, and local. An example of this type of insurance is Medicare. **Public welfare insurance** is based on financial need. The primary example of public welfare insurance is Medicaid. All insurance plans define a contract between the beneficiaries, the purchasers, which are the employers and government, the health plan organizations, and the providers who deliver the services (Pointer et al., 2007). There are also self-insurance programs that are administered by employers who bear the financial risk of providing their own health insurance to their employees. The funds to operate the program are derived from employee premiums. Reimbursement of health services are taken from this pool of funds rather than from another health insurance company.

There are two forms of payment, fee for service and prepayment, that provide the basis for all health insurance coverage. **Fee for service**, developed by BCBS, is based on the concept of a person purchasing coverage for certain benefits, using the health insurance coverage for these designated benefits, and paying the provider for the services provided. The provider may be paid by the insurance coverage or out of pocket by the patient. In a **prepayment** concept, the individual pays a fixed, predetermined amount for the services rendered. Managed care organizations follow a prepayment model (Sultz & Young, 2006).

COST SHARING OF HEALTH SERVICES

Most insurance policies require a contribution from the covered individual in the form of a copayment, deductible, and/or coinsurance. This concept is called **cost sharing**. Used in both fee-for-service and prepaid plans, **copayments** are costs that the patient must pay at the time they receive the services. It is a designated dollar amount. A type of copayment, **coinsurance**, which is part of a fee-for-service policy, the patient pays a percentage of the cost of the services. A typical coinsurance portion is 20% paid by the individual with the remaining 80% paid by the health insurance plan. **Deductibles** are payments that are required prior to the insurance paying for services rendered in a fee-for-service plan. Deductible amounts vary from individual and family health insurance coverage and cover one calendar year. For example, an individual may have a $250 deductible per calendar year, which means they must pay the $250 before their health insurance covers the services. Unfortunately, the growth in health insurance premiums is an excellent barometer to measure changes in private health insurance costs. Employee premiums have increased between 8 and 14% since 2000. The increase in premium costs has increased the percentage of cost sharing of health insurance on the employee (KFF, 2007). The main issue with the increase in cost sharing is its impact on individuals utilizing healthcare services. A study published in the *New England Journal of Medicine* concluded that adding an additional cost-sharing measure, such as a copayment of $10, reduces the number of women who received a mammography. These results concur with similar studies that examine cost sharing for health screening services (Bach, 2008).

HEALTH INSURANCE LIMITATIONS

Most plans include a stop-loss provision, which is the **maximum out-of-pocket expenditure** that occur in a

given year. Once this level has been reached by the individual, the insurance company will pay 100% of the expenses. A **lifetime cap** may be established by a health insurance company, which means the company will usually pay a limit of $1,000,000 or higher for health services rendered. This lifetime cap occurs when an individual incurs high expense levels as a result of a chronic condition (Pointer et al., 2007).

TYPES OF HEALTH INSURANCE POLICIES

Comprehensive health insurance policies provide benefits that include outpatient and inpatient services, surgery, laboratory testing, medical equipment purchases, therapies, and other services such as mental health, rehabilitation, and prescription drugs. Most comprehensive policies have some exclusion attached to their policies. The opposite of comprehensive health insurance policies is **basic** or **major medical policies**, which reimburse hospital services such as surgeries and any expenses related to any hospitalization. There are limits on hospital stays. **Catastrophic health insurance** policies cover unusual illnesses with a high deductible and have lifetime reimbursement caps. There are also specific health insurance policies such as **disease-specific policies** for cancer, etc., and **medigap policies** that provide supplemental insurance coverage for Medicare patients (Shi & Singh, 2008).

TYPES OF HEALTH INSURANCE PLANS

There are two basic types of insurance plans: **indemnity plans** which are fee-for-service plans and managed care plans, which include HMOs, preferred provider organizations (PPOs), and point-of-service (POS) plans. Indemnity plans are contracts between a beneficiary and a health plan but there is no contract between the health plan and providers. The beneficiary pays a premium to the health plan. When the beneficiary receives a healthcare service, the plan will reimburse the beneficiary an established fee for a particular service regardless of the provider's fees. The beneficiary will then reimburse the provider directly (Sultz & Young, 2006).

The managed care plan, which is discussed in depth in Chapter 8, is a special type of health plan that focuses on cost containment of health services. The first type of managed care organization was the HMO, which evolved in the 1970s. As managed care organizations evolved, different types of managed care organizations developed.

Managed care plans combine health services and health insurance functions to reduce administrative costs. For example, an employer contracts with a health plan for services on behalf of their employees. The employer is required to pay a set amount per the enrolled employee on a monthly basis. The contracted health plan has a contract with certain providers to whom it pays a fixed rate per member on a monthly basis for certain services. Enrolled employees may cost share with a copayment. There is no deductible. The enrolled employees have restrictions on their choice of providers or incur larger copayments if they choose a provider out of the network.

A recent trend in health insurance plans is **consumer-driven health plans** (CDHPs) that are tax advantage plans with high deductible coverage. The most common CDHPs are **health reimbursement arrangements** (HRAs) and HSAs. HRAs or **personal care accounts** began in 2001 as a result of an Internal Revenue Service (IRS) regulation. An HRA is funded by the employer but owned by the employees and remains with the company if the employee leaves. This has been an issue because it has no portability (Wilensky, 2006).

An **HSA**, which was authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pairs high deductible plans with fully portable employee-owned tax-advantaged accounts. This plan encourages consumers to become more cost conscious when using the healthcare system because they are using their own funds for healthcare services. The HSA, unlike the HRA, is a portable account, which means it can be transferred to another employer when the employee changes jobs. HSAs encourage consumers to understand healthcare service pricing because these accounts are paired with a high deductible. America's Health Insurance Plans (AHIP), an industry trade association, estimates that 4% of firms that offered benefits also offered an HSA or HRA (Wilensky, 2006).

Other types of CDHPs include **flexible spending accounts** (FSAs) and **medical saving accounts** (MSAs). **FSAs** provide employees with the option of setting aside pretax income to pay for out-of-pocket medical expenses. Employees must submit claims for these expenses and are reimbursed from their spending accounts. The drawback is that the amount set aside must be spent within 1 year. Any unspent dollars cannot be rolled over so it is very important to be very specific about the projected medical expenses. Mandated as part of HIPAA, the **MSA** allows workers employed in firms

with 50 or less employees, and who have high deductible health insurance plans, to set aside pretax dollars to be used for healthcare premiums and nonreimbursed healthcare expenses (Buchbinder & Shanks, 2007).

As discussed previously, self-funded or self-insurance programs are health insurance programs that are implemented and controlled by the company itself. They retain all of the risk in providing health insurance to their employees by paying any claims from their employees. Both the employee and employer pay into the fund. The employer maintains a trust that is overseen by federal regulation. All claims are paid from the trust. The company will purchase reinsurance from another insurance company to protect themselves from any catastrophic losses. The **reinsurance** sets a **stop-loss measure** that limits the amount the company will pay for claims (Employee Benefit Management Service [EBMS], 2009).

Long-term Care Insurance

As the life expectancy continues to increase in the United States, more people will require more healthcare services for chronic conditions. Unfortunately, Medicare and traditional health insurance policies do not pay for long-term care. Medicaid will pay for long-term care if you qualify for their program. **Long-term care insurance** was developed to cover services such as assistance with activities of daily living as well as care in an organizational setting. The cost of long-term care insurance can vary based on the type and amount of services selected as well as the age at time of purchase and healthcare status. If an individual is already receiving long-term care or is in ill health, a person may not qualify for long-term care insurance. Most long-term care insurance policies are comprehensive, which means they will cover expenses from home health care, hospice, respite care, assisted living, nursing homes, Alzheimer special care, and adult day centers. Long-term care policy costs vary greatly based on age and type of policy. The average annual premium for a policy purchased in 2007 by individual buyers of all ages was $2200 (Department of Health and Human Services [HHS], 2009).

The National Clearinghouse for Long-Term Care Information has provided the following information for purchasing long-term care insurance:

- The policyholder can select a daily benefit amount, which can range from $50 to $500 per day. The policyholder can select how much is paid on a daily basis, depending on the healthcare setting. The type of healthcare setting can also be identified such as home health care or skilled nursing facility.
- The policyholder can select a lifetime amount the policy will provide, which can range from $100,000 to $300,000. More expensive policies will allow unlimited coverage with no dollar limit.
- The policyholder can also select an inflation option, which adjusts the coverage amount as you age.
- Some policies may pay for family/friend long-term care for the policyholder. The policy may also provide reimbursement for equipment or transportation.

There are currently 100 companies that represent 15 insurers that offer long-term care nationally. More employees are now offering long-term care insurance as an option to their employees. Employers do not contribute to the premium cost but may negotiate a better group rate. Long-term care insurance is becoming more popular because individuals are recognizing that their traditional health insurance and Medicare will not pay for long-term care (HHS, 2009).

PUBLIC FINANCING OF HEALTHCARE SERVICES

Since 1965, public financing has played a large role in providing healthcare services to the elderly, disabled, and the indigent. Medicare and Medicaid are the two largest government-sponsored health insurance programs in the United States. Medicare, Title XVIII of the Social Security Act, provides medical care for (1) individuals who are 65 years and older, (2) disabled individuals who are entitled to Social Security benefits, and (3) people who have end-stage renal disease (Shi & Singh, 2008). According to the KKF, in 2006, 88% of Medicare enrollees were 65 years and older, 56% were female, and 41% were considered indigent (KFF, 2007). Medicare is an **entitlement** program because people, after paying into the program for years, are entitled to receive benefits. It is important to emphasize that Medicare and Medicaid have provided access to healthcare services through their programs. The number of uninsured in the United States would be much higher if these programs did not exist (Enthoven & Fuchs, 2006).

Medicare

CMS has oversight of Medicare. There are currently 43 million Medicare enrollees. Projections are expected to increase to 60 million by 2050. Medicare is the healthcare industry's largest payer. Medicare originally was designed as a two-part structure: Part A for hospital insurance and Part B for supplemental or voluntary medical insurance. Recently, two additional parts were added: Part C, Medicare+Choice/Medicare Advantage and Part D, which is a prescription drug plan benefit (CMS, 2009a).

Medicare Part A Hospital Insurance

Medicare Part A is primarily financed from payroll taxes. The employer and employee contribute to the Social Security (Medicare) fund. Employees contribute 1.45% of wages which is matched by employers. Self-employed individuals pay 2.9% of earnings. Part A covers hospital inpatient services, care in a skilled nursing facility, home health visits, and hospice care. The following is a summary of Part A benefits:

- Hospitalization, skilled nursing facility services, some home health, and hospice are available premium free to individuals 65 years or older when they have been receiving Social Security disability benefits for 24 months. Others can utilize these services but must pay a premium and must enroll in Part B. Enrollment for Part A is January to March of each year with benefits beginning July 1 of that year.
- A maximum of 90 days of inpatient hospital care is allowed per episode of illness with a lifetime reserve of 60 additional hospital inpatient days remain when the 90 days has exceeded.
- Medicare patients pay a deductible of one hospital day of care with copayments for each of the 65 to 90 day, equal to 25% of the deductible (CMS, 2009a).

Medicare Part B Voluntary Medical Insurance

Medicare Part B is a supplemental health plan to cover physician services. It is financed 24% from enrollee premiums and 76% from federal treasury funds. The following is a summary of Part B benefits:

- Coverage includes physician care, durable medical equipment, physician-ordered supplies, ambulatory surgical services, outpatient hospital care, outpatient mental health services, and laboratory services. Part B is made available when enrollees sign up for Part A (CMS, 2009a; KFF, 2007).

Medicare Part C Medicare Advantage

Medicare Part C is also referred to as Medicare Advantage. It is required to cover all services in Parts A and B. It is voluntary and available when an individual enrolls in Parts A and B. This program was designed to move Medicare patients into more cost-effective health insurance programs such as HMOs or PPOs. Enrollment is November 15 to December 31 of each year with benefits starting January 1 of the next year. Part C also established antifraud and abuse programs; additional prevention programs for prostate cancer, colorectal screenings, and mammography; rural initiatives; and the establishment of the State Children's Health Insurance Program (SCHIP) for low income children (CMS, 2009a).

Medicare Part D Prescription Drug Benefit

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which authorized **Medicare Part D**, produced the largest additions and changes to Medicare and was projected to cost nearly $750 billion in the first 10 years. Tax revenues of the federal government supports approximately 78% of the program costs, 10% is financed through monthly premiums, 11% is financed by state payments, and 1% from other sources (Buchbinder & Shanks, 2007; Shi & Singh, 2008). Its purpose was to provide relief from costly prescription costs for seniors. Like Part B, it is a voluntary program because enrollees pay a premium for coverage. Effective January 1, 2006, this program developed a prescription drug program for enrollees. The following is a summary of Part D benefits:

- Affordable prescription drug plans were made available for Medicare Advantage plan enrollees and traditional Medicare health plans.
- For seniors who are considered indigent, the MMA established a low income subsidy for the costs of Part D (CMS, 2009a).

Medigap

Medicare covers less than half of total healthcare costs for an enrollee, which leaves them with substantial out-of-pocket expenses. To cover these expenses, Medicare enrollees can receive additional coverage from (1) Medicaid if the Medicare enrollee is eligible, (2) enrollment in

Medicare Advantage which can provide supplemental coverage, (3) employer-sponsored retiree insurance, and (4) purchase supplemental insurance policies from private insurance companies which are called medigap policies (Sultz & Young, 2006).

Medicaid

Medicaid, Title XIX of the Social Security Act, provides health insurance to the medically indigent. It is a welfare program that is administered at the state government level. The program serves 45 million low income Americans. Medicaid spending varies based on the status of the US economy. It is not a federally mandated program; however, all states have Medicaid except Arizona. Managed care enrollment has controlled Medicaid spending. Eligible people include: (1) families with children receiving support under the Temporary Assistance for Needy Families (TANF), (2) people receiving Supplemental Security Income (SSI), and (3) children and pregnant women with income at or below 133% of the federal poverty level, and (4) children whose parents have income too high for Medicaid but too low for private insurance (CMS, 2009a; Shi & Singh, 2008).

All states administer their own program so eligibility varies by state. State programs must match federal funding for their programs and must provide the following services: inpatient and outpatient hospital services, physician care, nursing facility services, home health services, prenatal care, family planning services, health services for children under 21, midwife services, and pediatric and family nurse practitioner services. State programs are responsible for at least 40% of the costs for provider services and must equally share the administrative costs of the Medicaid programs (CMS, 2009a; Sultz & Young, 2006). States have the right to determine the eligibility criteria for Medicaid enrollment, optional services to provide, methods and rates for provider payments, and utilization limits for services (Pointer et al., 2007).

State Children's Health Insurance Program (now Children's Health Insurance Program)

Authorized by the Balanced Budget Act of 1997, and codified as Title XXI of the Social Security Act, SCHIP, now CHIP, was initiated in response to the number of children who are uninsured in the United States. The CHIP gave states $40 billion over a decade to provide health care for these children. This program offers additional funds to states to expand Medicaid benefits to children younger than 19 years of age who otherwise may not qualify because the family income exceeds Medicaid levels. This program, like Medicaid, is a federal–state partnership with the federal government paying nearly 75% of the cost. The federal fund was a block grant, which means the funds can expire. In February 2009, President Obama extended the authorization of CHIP funding and increased eligibility for an additional 4 million children (Families USA, 2009).

Program of All-Inclusive Care for the Elderly

Also authorized by the Balanced Budget Act of 1997, Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive healthcare delivery system funded by Medicare and Medicaid. Oversight is provided by CMS, and it is modeled from a San Francisco, CA, senior healthcare center, On Lok Senior Health Services. The PACE model focuses on providing community-based care and services to people who otherwise need nursing home levels of care. Their philosophy is that seniors with chronic care needs are better served in the community when possible. Implemented at the state level, PACE can be offered as a Medicaid option. Participants must be Medicare eligible or 55 years or older with a disability, live in a PACE area, and be certified for nursing home care. An interdisciplinary team assesses the needs of the patient and develops a long-term plan. The PACE model provides services of Medicaid and Medicare but in an integrated manner. They provide both medical and social services as needed. PACE providers are reimbursed from Medicare and Medicaid payments. As of 2008, there were 61 PACE programs operational in 29 states (CMS, 2009b; National PACE Association, 2009).

Worker's Compensation

The employer is financially liable for employees who become injured or ill as a result of working conditions. **Worker's compensation** is a state administered program. Employees may receive cash for lost wages, payment for medical treatment, survivor's death benefits, and indemnification for loss of skills. Although worker's compensation is not a traditional health insurance program, it does provide medical benefits. The main difference between employer health insurance programs and worker's compensation is that the employer must cover the full cost of the benefits (Department of Labor, 2009; Shi & Singh, 2008).

TRICARE

The US Department of Defense operates the Military Health Services System (MHHS) which provides medical services to active duty and retired members of the armed services. As the active duty numbers increased, a special medical care program called **TRICARE** was developed to respond to the growing needs of retired members. TRICARE is regionally managed, structured after managed care, and coordinates the efforts of the Navy, Army, and Air Force. They have an HMO type operation, a PPO type organization, and a traditional fee-for-service program. There are 11 TRICARE regions in the United States with other TRICARE operations in Europe, Latin America, and Pacific (TRICARE, 2009).

Indian Health Service

The Indian Health Service (IHS), a division of HHS, provides comprehensive healthcare services directly to nearly 2 million American Indian and Alaska Native tribes. Their annual budget is approximately $3 billion. This system includes 33 hospitals, 59 health centers, and 50 health stations (IHS, 2009).

REIMBURSEMENT METHODS OF PRIVATE HEALTH INSURANCE PLANS

As healthcare costs have escalated, the government has developed various mechanisms aimed at standardizing reimbursement for healthcare services. Later, insurance companies developed standards for **usual, customary, and reasonable (UCR) services** based on community and state surveys of provider charges. If there was a difference in the reimbursement rates, the provider asked the patient to pay the difference. The problem with fee-for-service reimbursement methods is that it may have become a tool for some physicians to increase the number of services provided to the patient as a way to increase their income (Shi & Singh, 2008).

Insurance companies, managed care organizations, and the government are referred to as **third-party payers.** The other parties are the patient and the healthcare provider. The payment function in healthcare determines the how and how much is reimbursed for the services. Fee for service, which was discussed previously, is the preferred method of reimbursement by providers. Historically, providers set the rate for their services that the government and health insurance companies paid without question. This type of **retrospective reimbursement** determines the amount of reimbursement after the delivery of services and provides little financial risk to providers. This type of reimbursement method contributed to the increase in healthcare costs (Feldstein, 2005).

The most common type of reimbursement is a **service benefit plan.** This type of **prospective reimbursement** method was developed and used primarily by managed care organizations. The employer has a contract with a benefit plan and pays a premium for each of its employees. Employees usually pay a portion of the premium to the health plan also. The health plan contracts with certain providers and facilities to provide services to their beneficiaries at a specified rate and makes payments directly to the providers for their services (McLean, 2003).

Beneficiaries/employees and families may have a cost-sharing arrangement with their employer for these services, such as deductibles and coinsurance payments, that provide payment to providers upon the receipt of a service. HMOs are examples of service benefit plans. In a managed care organization, the organization reimburses the provider at a **capitated rate,** which means they receive a set rate for serving enrolled patients regardless of how much care the provider gives. This type of capitation is also used by Medicaid and Medicare for their managed care programs (Pointer et al., 2007).

OTHER PROSPECTIVE REIMBURSEMENT METHODS

Per diem or **per patient day** is a defined dollar amount per day for care is provided. This is the most common form of reimbursement to hospitals. **Cost–plus reimbursement,** a type of retrospective reimbursement, was the traditional method used by Medicare and Medicaid to establish per diem rates for inpatient services. Under this method, reimbursement rates for institutions are based on the total costs incurred in operating the institution which are used to calculate the per diem or per patient day rate. The method is called cost–plus because, in addition to the operating costs, the reimbursement rate allows a portion of the capital costs to determine the rate (Buchbinder & Shanks, 2007; Shi & Singh, 2008; Sultz & Young, 2006).

Other reimbursement methods include:

- **Per diagnosis**: A defined dollar amount is paid per diagnosis. These types of rates are also used for Medicare reimbursements.

- **Bundles for hospital and physician services:** A fixed amount is paid by the managed care organization for patient treatment and is shared by all providers.
- **Fee schedule by current procedural terminology (CPT) code:** The most common method of reimbursement for specialty physicians. The more complex procedure, the higher the rate of reimbursement (CMS, 2009a).

GOVERNMENT REIMBURSEMENT METHODS FOR HEALTHCARE SERVICES

The federal government has sought to control healthcare expenditures through programs such as DRGs, ambulatory patient groups (APGs), ambulatory payment categories (APCs), home health resource groups (HHRGs), resource utilization groups (RUGs), and resource-based relative value scales (RBRVSs). States also used regulatory efforts such as certificate of needs (CONs) to control expenditures. Also, Medicaid growth costs have been limited by hospital preadmission screening, limiting hospital stays, reducing per diem rates, increasing copayments, and decreasing service coverage. Reducing Medicaid reimbursements creates issues of **cost shifting**. Healthcare organizations must find other ways to be reimbursed or they will not be profitable so they raise the prices to privately insured patients to offset the small reimbursement charges of Medicaid and Medicare (Feldstein, 2005).

Hospital Reimbursement

In 1982, Congress passed the **Tax Equity and Fiscal Responsibility Act** (TEFRA) and the **Social Security Amendments of 1983** to manage Medicare cost controls. There was a mandate to hospitals for a **prospective payment system** (PPS) to establish reimbursement rates for certain conditions. CMS reimburses hospitals per admission and per diagnosis which is based on a **DRG**—a prospective payment system for hospitals established through the Social Security Amendments of 1983. Each DRG group represents similar diagnoses of diseases that are expected to have similar use of hospital services. The amount of reimbursement is set per discharge of a patient. Hospitals that can provide services at lower costs may keep the difference in the reimbursement rates (Longest & Darr, 2008).

Resource-based Relative Value Scale

Under the Omnibus Budget Reconciliation Act of 1989, Medicare developed a new initiative of **RBRVS** to reimburse physicians according to a relative value assigned to a service. This reimbursement is divided into three components: physician work, practice expenses, and malpractice insurance. Medicare pays a flat fee for physician visits and is based on the Healthcare Common Procedure Coding System which is used to code professional services. The RBRVS, implemented in 1992, has become a standard Medicare Part B reimbursement method. This system increased reimbursement for family and general practice by about 15%. Also, physicians who had not signed a Medicare participation agreement, meaning they do accept Medicare reimbursement as the full payment for services, were prevented from **balance billing** so the physician is not able to bill the patient the difference between Medicare payments and the physician charges. The statute limited the amount the physician could balance bill the patient (Longest & Darr, 2008).

Ambulatory Patient Groups/Ambulatory Payment Categories

APGs were developed in the 1980s and are a system of codes that explained the number and types of services used in an ambulatory visit. Similar to the DRG classification, patients per APG had similar clinical classifications, resource use, and costs.

Implemented in August 2000, **APCs** were adapted from the APGs. The APC divides all outpatient services into 300 procedural groups/classifications based on similar clinical content such as surgery, medical, and ancillary services. Each APC is assigned a payment weight based on the median cost of services within the APC. The rates are also adjusted for wage differential by location. This type of rate is a bundled rate established by Medicare (CMS, 2009a).

Resource Utilization Groups

This type of prospective payment systems for skilled nursing facilities, used by Medicare, provides for a per diem based on the clinical severity of patients. A classification system called **RUG**, a type of DRG, was designed to differentiate patients based on how much they use the resources of the facility. As the patient's condition changes, the rate of reimbursement changes. A per diem rate was established using these classifications (Longest & Darr, 2008; Shi & Singh, 2008).

Home Health Resource Groups

Implemented in October 2000, the **HHRG**, which is a prospective payment used by Medicare, pays a fixed predetermined rate for each 60-day episode of care, regardless of the services. All services are bundled under a home health agency. The HHRG uses 80 distinct groups to classify patients' conditions (Longest & Darr, 2008).

HEALTHCARE FINANCIAL MANAGEMENT

Although for-profit and not-for-profit healthcare organizations have different missions, both types of organizations have financial objectives to achieve. The most common are: (1) generating a reasonable net income to continue effective operations, (2) setting prices for services, (3) contracting management of third-party payers such as Medicare and Medicaid and health service providers, (4) analyzing information for cost control, (5) adhering to governmental regulations such as reimbursement methods, and (6) minimizing financial risk (Buchbinder & Shanks, 2007). To ensure these objectives are met, many healthcare organizational structures include the following positions to supervise the financial management function. The **chief financial officer** (CFO) supervises the **comptroller** who is charged with accounting and reporting functions. The CFO may also supervise the **treasurer** who is responsible for cash management, banking relations, accounts payable, etc. An **internal auditor** who reports to the CFO ensures that accounting procedures are performed in accordance with appropriate regulations (McLean, 2003). All of these positions ensure that the organization is focusing on its mission to provide quality healthcare services. If there is no strong financial management system in place, the organization will fail.

FUNDS DISBURSEMENT

After services are delivered, the agency has to verify and pay the claims received from the providers. Disbursement of funds, which is often called **claims processing**, is carried out in accordance of the administrative procedures of the program. Most insurance companies and managed care organizations have a claims department to process payments. Self-funded insurance programs often hire a third-party administrator to process claims. Medicare and Medicaid contract with commercial insurance companies to process claims for them (Pointer et al., 2007).

CONCLUSION

As healthcare expenditures continue to increase, the major focus of the healthcare industry is cost control in both the public and private sector. For years, healthcare costs were unchecked. The concept of **retrospective reimbursement methods** for healthcare services, which means that a provider submitted a bill to a health insurance company that automatically reimbursed the provider, had no incentive to control costs in health care. This type of reimbursement method contributed to expensive health care for both the healthcare insurance companies and the individual who was paying out of pocket for their services. The establishment of a prospective reimbursement system for Medicare, which means a reimbursement system was developed based on care criteria for certain conditions regardless of providers costs, was an incentive system for providers to manage how they were providing services. The DRGs, RUGs, and RBRVs are examples of this type of reimbursement method. The focus now is efficiency and quality.

Also, the implementation of managed care organizations has focused on cost control. Although healthcare spending decreased in the 1990s, healthcare costs have continued to increase since. The implementation of CDHPs have assisted individuals with controlling healthcare costs by providing opportunities to save money for health care while obtaining a tax advantage. However, with the economic recession, there will be an increased number of individuals for a period of time that will have no health services because they are unemployed. This is a potential healthcare crisis because a large percentage of individuals historically have received their health care through their employer. This problem may further burden the government at all levels as individuals become eligible for public programs. The current administration has indicated that health care is a priority for implementing new public policy so any new initiatives may attempt to rectify this serious situation.

PREVIEW OF CHAPTER EIGHT

Managed care organizations revolutionized how healthcare services were delivered. Their focus was cost control as a result of the continued increasing cost of national healthcare expenditures. Managed care organizations developed a network of providers who belonged to the

organization. HMOs were the original model for managed care organizations. The consumer had to choose these providers for their care. This model was an adjustment to both providers and patients. Providers were threatened by loss of income and consumers felt they lost control of the ability to choose their own provider. As the model has evolved, there have been modifications on how managed care has focused on consumer preferences while still maintaining cost control measures. Depending on the managed care model, providers were allowed to care for both managed care consumers and their own private patients. PPOs allowed consumers to choose their provider although they were required to pay an additional cost share if their physician was not within their network. Over the past decade, other models have been developed to address continued physician and consumer concerns. Chapter 8 will discuss the history of managed care organizations, the different models of managed care, issues regarding managed care, and how it has impacted traditional healthcare services. As a consumer it is very important for you to understand the managed care models because many of you either are participating in a managed care organization or will be using a managed care organization for your primary care.

VOCABULARY

Ambulatory patient groups (APGs)

Ambulatory payment categories (APCs)

Balance billing

Bundles for hospital and physician services

Capitated rate

Catastrophic health insurance

Chief financial officer (CFO)

Children's Health Insurance Program (CHIP)

Claims processing

Coinsurance

Comprehensive health insurance policies

Comptroller

Consumer-driven health plans

Copayments

Cost–plus reimbursement

Cost sharing

Deductibles

Diagnosis-related group (DRG)

Entitlement program

Fee for service

Fee schedule for CPT code

Flexible spending accounts (FSAs)

Group insurance

Health insurance

Health reimbursement arrangements (HRAs)

Health savings accounts (HSAs)

Home health resource group (HHRG)

Indemnity plans

Individual private health insurance

Internal auditor

Lifetime cap

Major medical policies

Managed care plans

Maximum out-of-pocket expenditures

Medical saving accounts (MSAs)

Medicare Part A

Medicare Part B

Medicare Part C

Medicare Part D

Medicare Prescription Drug Improvement and Modernization Act of 2003

Medigap policies

National Clearinghouse for Long-Term Care Information

Out of pocket

Per diem

Prepayment

Program of all-inclusive care for the elderly (PACE)

Prospective reimbursement

Public welfare insurance

Reinsurance
Resource-based relative value scales (RBRVs)
Resource utilization group (RUG)
Retrospective reimbursement
Self-insurance/self-funded insurance programs
Service benefit plan
Social insurance
Stop loss measure
Third party payer
Treasurer
TRICARE
Usual, customary, and reasonable services (UCR)
Voluntary health insurance
Worker's compensation

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