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RESEARCH STARTERS
ACADEMIC TOPIC OVERVIEWS

Financing of Health Care Delivery

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Abstract

Who pays for health care? In the United States, the financing of health care delivery is a tangled web of private insurance companies, employers, state and federal governments, and individual consumers. Despite the passage of the Patient Protection and Affordable Care Act in 2010, which expanded access to health care coverage, the United States remains one of the few developed nations that does not provide universal health coverage to its citizens. As measured by percent of gross domestic product (GDP), the United States also pays more for health care than any other developed nation. Paying for health care is a complex, politically charged enterprise. In this essay, the major players in the health care arena are described and a brief discussion of approaches to health care finance reform are presented.

Overview

Historically, health care was most often provided by the family in the home. Doctors were called in to attend the sick only as a last resort. This was in part because doctors had a limited range of medicines and technologies to use. Physician fees were low and payment, especially in rural areas, was often rendered in the form of foodstuffs or services. Hospitals existed, but they existed as religious and charitable institutions that served the poor, the elderly, and the mentally ill. Hospitals depended on wealthy community sponsors for financing, and hospital staff members were predominantly volunteers.

With advances in treatment, scientific and technological breakthroughs, and the understanding of asepsis, the identity of hospitals transformed from warehouses for the poor and infirm to modern venues for treatment and care. With this transformation emerged a new partnership for physicians and hospitals. Physicians needed hospitals as a clean, organized, and fully staffed venue for their medical practice. Hospitals needed physicians for their patient base and medical expertise. Hospitals also became increasingly important as medical teaching and training sites. In this symbiotic relationship, the first great divide in the financing of medical care began to emerge. Physicians retained their medical expertise and charged patients accordingly. At the same time, hospitals emerged from being strictly room-and-board charity institutions to complex organizations requiring skilled workers and specialized equipment, so hospitals began establishing their own system of patient costs and payment structures. In some instances, city governments assisted with hospital funding as part of a larger program of public service infrastructure. Increasingly, individual patients were able to pay for their own costs of care (Starr, 1982).

This cost structure of physicians and professional fees on the one hand, and the bricks and mortar and equipment of the hospital on the other hand, underlies the financial structure of paying for health care up to the present day. In the following sections, the major players and their roles in health care finance are described.

Employer-Based Insurance. Employer-based health insurance has long accounted for the majority of health care coverage in the United States. According to US Census data, more than half of the US population (56 percent) had employment-based health insurance coverage in 2017. Such coverage may come from one's own employer, or from a spouse or other person's employer.

Employer-based health insurance began in the late 1920s. With the Great Depression as an impetus, hospitals came together to offer a plan of hospital insurance as a means to ensure that patients would be able to pay their hospital costs. One of the earliest plans was Blue Cross, formed in 1929. The most notable feature of the

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Blue Cross plan was that it was offered only through employers. In 1947, Associated Medical Care Plans was formed as the first national association of Blue Shield plans.

Enactment of the National Labor Relations Act of 1935 served as a further impetus for employer-based health insurance. Under the wage and price controls mandated by this act, employers could not recruit workers using higher wages as a lure nor could they increase existing wages to retain current workers. The use of benefit packages became an important tool for employee recruitment and retention. Health insurance coverage was an especially attractive feature in the benefit package for employers as well as employees for two reasons:

- First, the benefit was exempt from income and payroll taxes for the employee
- Second, the employer could write off the cost of insurance coverage as a cost of doing business.

In 1940, approximately 10 percent of American workers had employer-based health insurance. By 1955, this percentage increased to 70 percent (Blue Cross Blue Shield, 2007).

However, with rising health care costs and fluctuations in the economy, the number of employers offering health insurance as a benefit began to drop in the late 1990s. The likelihood of employment-based coverage declined from 64.4 percent in 1997 to 56.5 percent in 2010 (Janicki, 2013). Small firms with few employees particularly struggled to provide coverage; in 2001, only 39 percent of firms with ten employees or less offered health insurance to their employees as compared to 95 percent of firms with 100 to 999 employees and 99 percent of firms with over one thousand employees (Glied, 2004). One of the reasons it is difficult for small businesses to supply employment-based health care coverage is they do not have enough employees to reduce their actuarial risks, so smaller businesses cannot secure premiums as cheaply as large companies (Ubel, 2013). The Affordable Care Act (ACA) passed in 2010 sought to address this issue by making small employers with fifty or fewer employees eligible for a tax credit if they offered employment-based health insurance coverage.

Medicare. Medicare is the health care industry's single largest payer of health care services. Medicare is an entitlement program for US citizens aged sixty-five years and older. It was enacted in 1965 as Title 18 of the Social Security Act and is especially notable as one of the cornerstones of President Lyndon Johnson's Great Society social programs. In addition to providing health care coverage for persons sixty-five years and older, Medicare also provides coverage to individuals eligible under Social Security disability and for all persons with end-stage renal disease. Medicare is funded through payroll deductions made during an individual's working career. The program is administered by the Centers for Medicare and Medicaid (CMS), an agency in the US Department of Health and Human Services. Medicare services are divided into several components.

Medicare Part A. Medicare Part A provides insurance for acute care hospitalization. Acute care refers to any medical condition that is diagnosed and successfully cured. Examples include a broken bone, an intestinal disorder, a fungal rash, and other more or less complicated diseases. Medicare Part A also covers skilled nursing care services, in the home or in a health care facility, and pays for hospice care. Medicare does not pay for long-term care services in a nursing home. Long-term care refers to a condition that can be diagnosed but not necessarily cured and must be treated by managing the symptoms or effects of the disease. Examples include arthritis, diabetes, and some forms of cancer, among others.

Under Medicare Part A, up to ninety days of hospitalization is covered for each individual medical event. When Medicare was first enacted, hospitals submitted claims for cost reimbursement to the Health Care Finance Administration (the forerunner of CMS). Reimbursement rates for each hospital were set according to a complex set of formulas and regulations. As reimbursement costs rapidly escalated, a new protocol for reimbursing hospitals was adopted. In 1983, Medicare reimbursement was changed from the customary fee-for-service reimbursement plan to a prospective payment system. In this new system of reimbursement, medical conditions and diseases are classified into five hundred diagnostic related groups (DRGs). Each DRG category is based on a set of criteria that include age, sex, diagnosis, treatment, expected length of stay, and expected use of hospital resources. A predetermined reimbursement rate is set within each DRG. The use of prospective using DRGs was a cost containment and control measure. Since its inception with Medicare, commercial health insurance companies have adopted similar prospective payment approaches.

Medicare Part B. The second component of Medicare is Part B. Part B covers physician care, physician-ordered supplies, outpatient care, durable medical equipment, ambulance services, and care provided by various other technical medical professionals. Until 1992, physician reimbursement under Medicare Part B was calculated based on claims submitted by individual physicians deemed "reasonable and customary." After 1992, reimbursement was based on an index of resource-based relative value (RBRV). The index was developed by calculating and comparing the amount of work performed, practice expenses, and malpractice insurance costs. RBRV was also a measure designed to contain and control costs.

Medicare Part C and Part D. In December 2003, President George W. Bush signed the Medicare Modernization Act (MMA) into law. This landmark legislation had two important provisions. First, it allowed the entrance of commercial health insurance plans into Medicare (Medicare Advantage, or Medicare Part C). Second, MMA established a prescription drug plan for all Medicare enrollees. This is known as Medicare Part D. Part D is an insurance-based program and Medicare beneficiaries who choose to participate must pay a monthly premium.

Medicaid. Another hallmark of President Johnson's Great Society programs is Medicaid. Enacted under Title 19 of the Social Security Act, Medicaid is a health insurance program

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for the poor. Unlike Medicare, Medicaid is not an entitlement. Rather, Medicaid recipients must meet certain income and asset eligibility requirements. Medicaid is administered solely by the states and is funded jointly by state governments and the federal government. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage, which varies by state based on criteria such as per capita income. The average state FMAP is 57 percent but can range from 50 percent in wealthier states to up to 75 percent in states with lower per capita incomes. Each state determines its own eligibility criteria and services offered. Federal law mandates that minimum services to be provided include physician visits, hospital and outpatient services, nursing home, home health, and diagnostic testing.

Although Medicaid was established as a health insurance program for the poor, it evolved to become a primary funder of long-term care in nursing homes. Almost one-half of the nation's nursing home costs were paid by Medicaid in 2002 (O'Brien, 2005).

Children's Health Insurance Program (CHIP). The Children's Health Insurance Program was enacted in 1997 as Title 21 of the Social Security Act. Like Medicaid, it is a joint federal-state program. The purpose of CHIP is to provide health insurance to children who are ineligible for Medicaid. These are children whose families are generally known as the "working poor." Family income exceeds Medicaid eligibility levels but health insurance coverage is either not available through employers or is too costly. In 2018, 9.6 million children were enrolled in CHIP, according to the Medicaid.gov website. Like Medicaid, states have set eligibility and program coverage based on federal guidelines.

Managed Care. As health care costs began to rise sharply in the 1970s, private health insurers, employers, and state and federal governments began to look for ways to contain and control costs. Managed care emerged as one approach. Managed care refers to a type of medical organization or health system that controls and contains health care finances and delivery of health care services to its enrolled members. There are different structures to managed care plans, but the goals of each are the same: to ensure access to high-quality, medically necessary care by the most appropriate provider in the least restrictive setting. There are essentially three different types of managed care plans:

- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPO)
- Point-of-service plans (POS).

Health Maintenance Organizations. In an HMO, the plan contracts with health care providers to form a provider network. HMO members can only select a doctor, hospital, or other provider that is in this network. HMOs use a capitated system of financing where the HMO is paid a fixed amount per person (by an employer or an individual) for all care rather than a fixed amount based on fee per service. Thus the financial incentive for the HMO is to keep their members as healthy as possible in order to keep utilization of health care services low. The fewer services an enrolled member requires, the greater profitability for the HMO. One way HMOs control finances is by the use of a "gatekeeper," usually a primary care physician, who serves as a coordinator of care and referrals to specialists. HMO members cannot self-refer to specialty care without receiving pre-approval from their primary care physician gatekeeper. HMOs are considered to be the most restrictive type of managed care plan because of the use of the gatekeeper and because there are no out-of-network provider options.

Preferred Provider Organizations. A second type of managed care plan is the preferred provider organization (PPO). Like HMOs, PPOs contract with providers to form a network of health services. Unlike HMOs, a member is not required to have a primary care physician "gatekeeper." Also, members are not restricted from receiving care outside the network, although there are financial incentives to stay within the network of PPO providers. Out-of-network care usually incurs increased copayments, higher deductibles, and other out-of-pocket expenses.

Point-of-Service Plans. The third and least restrictive of the managed care plans is the point-of-service (POS) plan. This plan is most like a blend of HMO and traditional fee-for-service or indemnity plans. In a POS plan, a member can use the services of a provider network established by the POS; however, there is no gatekeeper and patients can self-refer to specialists outside of the plan. If a doctor within the plan refers a member to a specialist within the plan, most costs are covered. If the member self-refers outside the plan, there is very little coverage.

Medicare Modernization Act. In 2003, the Medicare Modernization Act expanded access to managed care plans for Medicare beneficiaries through Medicare Advantage plans. An HMO option has been available to Medicare enrollees since the early 1970s, but Medicare Advantage greatly expanded access to HMO, PPO, and POS options. In addition, special needs plans (SNPs) were created to cover "dual eligibles," those persons who are eligible for both Medicare and Medicaid benefits, and beneficiaries with long-term disabling conditions. In Medicare Advantage, the federal government pays a capitated fee to the Medicare Advantage plan. The plan in turn covers Part A and B services as well as Part D, the prescription drug benefit. Plans typically offer other supplemental services and benefits.

Health Care Reform. Despite efforts to control costs using managed care approaches, health care costs continued to rise into the twenty-first century. As overall costs rose, the number of Americans without access to care due to lack of health insurance continued to rise also. These concerns prompted frequent calls for major reform to the US health care system. Attempts at such reform have ranged from the introduction of new kinds of insurance and financing plans to major federal legislation.

Health Savings Accounts. The use of health savings accounts (HSAs) is a cost-containment approach that is one example of a category of health care finance called consumer-driven health plans. In these plans, as the name implies, the individual bears

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responsibility for how much they are willing to spend for health care. Researchers and critics point to the effect of moral hazard on utilization of health care services. Moral hazard refers to the effect of insurance availability on consumer demand for products or services. In the case of health care, the availability of health insurance creates an increased demand for health care services. The availability of insurance shields consumers from knowing the true cost of the health care services they use.

HSAs are designed to provide consumers with maximum flexibility in how they spend their health care dollars. HSAs pair a high-deductible insurance plan with a private savings account. The insurance plan must specify a minimum deductible the consumer must meet and a maximum out-of-pocket limit. Once the deductible is met and the out-of-pocket limit reached, the plan provides coverage in much the same way a traditional insurance plan operates. In some plans, 100 percent coverage is provided once the out-of-pocket limit is reached. In addition to the insurance plan, the consumer opens an HSA account at an approved financial institution. Deposits in the HSA are tax deductible. The deposits roll over from year to year allowing the consumer to save for large and unexpected medical expenses or can be withdrawn to pay for expenses not covered by the insurance plan.

In 1996, President Bill Clinton introduced the Medical Savings Act that pilot-tested the use of HSAs. In the Medicare Modernization Act of 2003, President Bush expanded the availability of HSAs.

Employers, especially small business employers, have often found HSAs to provide major cost savings. Large employers also began to add HSAs as an option in their benefit packages ("Employers offering HSAs," 2005). A census by America's Health Insurance Plans found that nearly 15.5 million Americans were covered by an HSA plan in 2013 (America's Health Insurance Plans, 2013). In 2018 the CDC reported National Health Interview Survey findings indicating that 18.9 percent of adults aged eighteen to sixty-four with employment-based insurance had high-deductible health plans with an HSA in 2017, a 10 percent increase from 2007.

HSAs are not without their critics. There are concerns that HSAs will replace traditional employer-based health insurance rather than being offered as an option. Another concern is that HSAs appeal mainly to healthier individuals, leaving less healthy and less well-off individuals to be covered by traditional insurance plans with the result being increased premiums for those individuals (Gorin, 2006).

Play or Pay. Play or pay is the shorthand term for health finance reform measures that mandate coverage, such as the Patient Protection and Affordable Care Act (ACA). When the ACA was signed into federal law in 2010, two states had already passed play-or-pay laws for health finance reform. The first, California, mandated that employers provide health insurance for all employees. In 2003, California passed SB 2, the Health Insurance Act of 2003. Under the provision of this bill, all employers were required to pay into a state fund to provide health care coverage for employees. Large firms that already had health insurance benefits for their employees would have received a credit against the mandated fee provided their health plan met state-defined qualifying standards. The strength of this plan was that it built on traditional health insurance plans. The weaknesses were that it did not provide universal coverage and it was highly controversial. California voters narrowly repealed the law less than a year after its enactment.

In July 2007, Massachusetts began implementation of a health reform plan that required all individual persons to purchase health insurance or pay a penalty to the state. If an affordable insurance product was unavailable on the market, individuals could obtain coverage through the Connector, the state health insurance purchasing entity.

Like the California plan, the Massachusetts plan built upon the existing health insurance market. The major players in the Massachusetts health policy arena worked together to craft the legislation and gain public support for its passage into law. The Massachusetts law was effectively replaced by the ACA, which used a similar model.

Patient Protection and Affordable Care Act of 2010. The Patient Protection and Affordable Care Act (ACA)—commonly called the Affordable Care Act or Obamacare, after its major backer, President Barack Obama—sought to reform a number of aspects of health insurance policy, as well as improve the access to and quality of health care services. With the passage of ACA, insurers were required to cover preventive services without deductible, copayment, or other out-of-pocket expense; to extend coverage to children with existing medical conditions; to cover young-adult children up to age twenty-six on their parents' plans; to spend most of their premiums on benefits to consumers rather than administrative costs; and to provide justification for rate increases. Starting in 2014, insurers could no longer set annual dollar limits on coverage, reject anyone based on preexisting medical conditions, discriminate against women, or restrict or deny coverage to those who participate in clinical trials. The ACA also expanded Medicare coverage through the state governments and requires employers with more than fifty full-time employees to provide basic health insurance for their workers or pay a tax penalty (US Department of Health & Human Services, 2013).

Furthermore, the ACA offered tax credits for small employers that provide insurance coverage for employees and affordable insurance options through the Small Business Health Options Program. Because insurance providers could no longer deny patients with preexisting medical conditions from attaining health insurance coverage under the ACA, an individual mandate required most Americans to secure health insurance coverage or pay a penalty for noncompliance. This was meant to ensure that a large enough number of healthy individuals sign up for and pay into health insurance so that the actuarial risks would be sufficiently distributed across the entire population and would not cause a spike in premium costs.

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The ACA was credited with cutting the number of uninsured Americans by approximately one half. It was also seen as a factor in reducing the annual rate of growth in health care spending to below 4 percent by 2017 (Martin et al., 2018). Nevertheless, the law, which had been hotly contested by lawmakers before its passage, remained a controversial political subject. Republicans repeatedly tried to repeal the ACA, without success. The conflict indicates the polarized nature of views on reforming an industry deeply connected to the economic and social structure of the United States.

Pay for Performance. Another approach to health care reform that differs from play-or-pay strategies is the 'pay for performance' model. The idea behind the 'pay for performance' approach to health finance reform is that payment for health care would be based on health improvements and outcomes and not for interventions and services used. This is a major departure from traditional fee-for-service plans. To effectively implement this approach requires that measures for outcomes and quality indicators be defined and developed. Although some such measures are underway, there is much work yet to be done.

Conclusion

Efforts to reform the nation's health finance systems are difficult and complex. The current system of health care finance in the United States has evolved over decades and the solutions inherent to this incrementally developed system will not be solved overnight. Health care reform was not deemed a problem until the number of uninsured persons, particularly middle-class working Americans, came to the attention of legislators and other policymakers. Health care is now a major issue on the national political agenda. Continued pressure from the business sector, health care providers, health policy experts, and consumers will keep the problem at forefront of the political arena but the ultimate solution is still a matter of debate.

Terms & Concepts

CHIP: The federal-state government program that pays children's health insurance for families who are ineligible for Medicaid.

Health Savings Accounts: A consumer-driven approach to paying for health care that uses high-deductible insurance with tax-advantaged savings plans.

Managed Care: An approach to health care finance that uses a third-party intermediary, such as an HMO, to coordinate and pay for health care services.

Medicare: The federal government program that pays health care costs for persons over the age of sixty-five.

Medicaid: The federal-state government program that pays health care costs for persons in poverty.

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Essay by Michele L. Kreidler, PhD

Michele L. Kreidler holds a doctoral degree in political science with a specialization in health and aging policy. Her research interest is in states adopting policies of retiree attraction as a strategy for economic development. In addition, she has over twenty years experience working in health care program development and administration.

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