HSCC 311
Systems & Trends in Health Care Delivery

Financing Health Care

Objectives

- Upon completion of this lecture, the participant should be able to:
  - describe the role of health care financing
  - describe the concept of insurance
  - differentiate between types of insurance
  - identify the differences in public and private financing
  - identify the various methods of reimbursement

Role of Financing

- Demand Side
  - Insurance premiums
  - Insurance as access
  - Demand related to financing
- Supply Side
  - Constrained reimbursement = diminished services
  - Affects management decisions
  - Affects health care professionals

Health Care Expenditures

- 1940
  - $4 billion
  - $30 per capita
  - $100 billion of GDP
  - 4% of GDP
- 1995
  - $988.5 billion total
  - $3,621 per capita
  - 7.3 billion of GDP
  - 13.6% of GDP
- 2003
  - $1.7 trillion
  - $5,670 per capita
  - 15.3% of GDP
- 2011 (CMS predicts)
  - $2.8 trillion
  - 17% of GDP

Sources of Funds

- Private funds
  - Consumer payments total $831 billion
    - Out-of-pocket: $230.5 billion
    - Private health insurance: $600.6 billion
  - Other private funds: $82.1 billion
- Public funds
  - Federal: $541.7 billion total
    - Medicare: $283.1 billion
    - Medicaid: $158.7 billion
    - Other federal: $99.8 billion
  - State and Local: $224 billion total
    - Medicaid: $109.9 billion
    - Other state and local: $114.1 billion
- Source: CMS

Insurance

- Principles
  - Risk is unpredictable
  - Insurance shifts risk
- Approaches
  - Indemnity (casualty)
  - Social

Insurance Concepts

- Insured
- Premiums
- Cost sharing
- Indemnity and service plans
- Covered services

Insured

- Beneficiary
- Single coverage plans
- Family coverage plans

Premiums

- Paid each month
- Employee shares cost
- Determining premiums
  - Experience rating
  - Community rating

Cost Sharing

- Individuals pay portion of premium and out-of-pocket
  - Deductible
  - Co-payment

Indemnity & Service Plans

- Indemnity
  - Fixed cash amount paid
  - Insured responsible for paying provider
- Service
  - Specified services to insured
  - Pays provider directly
  - Charges predetermined

Covered Services

- Most plans provide:
  - medical services
  - surgical services
  - hospitalizations
  - emergency services
  - prescriptions
  - maternity care
  - delivery of baby
  - mental health services
  - substance abuse services
  - home health care
  - skilled nursing care
  - rehab
  - supplies & equipment

Private Financing

- Growth of managed care
- Providers
  - BCBS
  - Commercial
  - Self-insured
  - Managed care organizations

Blue Cross Blue Shield

- Blue Cross
  - Hospital insurance system
- Blue Shield
  - Developed independently
  - Physician services

Commercial Insurance

- Commercial companies
  - Aetna
  - Metropolitan Life
  - Kaiser

Self-insurance

- Employers assume risk
- Greater degree of control
- Diminished due to managed care

Individual Private Health Insurance

- Individuals who rely on private insurance:
  - Farmers
  - Early retirees
  - Self-employed
  - Employee of business that does not offer coverage

Managed Care Plans

- Services provided by:
  - MCO's professionals
  - External providers
  - Combination
- MCO's
  - HMO's
  - PPO's
  - POS`

Health Maintenance Organizations

- Integrate
  - Delivery
  - Insurance
- Types
  - Staff model
  - Group model
  - Network
  - Independent practice association

Preferred Provider Organizations

- Limits beneficiaries
- Economic incentives
  - Lower premiums
  - Waiver of cost sharing

Point-of-Service Plans

- Members must go to providers in network
- Members have option to seek other providers as well
  - Increased cost

Public Financing

- Worker's Compensation
- Medicare
- Medicaid
- Balanced Budget Act Programs
- Military
- Department of Veterans' Affairs
- Indian Health Service

Worker's Compensation

- For costs and pain from job-related accident
- All 50 states
- Benefits
  - Cash replacement
  - Payment for medical care

Medicare

- Title VIII of Social Security Act
- Finances care for 65 and older
- Federal program under the Centers for Medicare and Medicaid Services (CMS)

Medicare Structure

- Programs
  - Hospital insurance (Part A)
  - Supplemental insurance (Part B)
  - Medicare+Choice (Part C)
  - Prescription drugs (Part D)

Medicare Financing

- Indirect pattern of finance and delivery
- CMS contracts with providers
- Fee-for-service for physicians
- Professional Standards Review Organizations (1972)
- TEFRA (1982)
  - Limits reimbursement
  - Precursor of prospective payment system

Medicaid

- Title XIX of Social Security Act
- Basic medical services to poor
- You must apply for it
- Certain categories automatically eligible
- Jointly financed
- State administered

Medicaid Financing

- Reimburses providers directly
- Personal Responsibility and Work Opportunity Reconciliation Act (1996)
  - Welfare reform
  - New restrictions
- BBA

Medicare vs. Medicaid

- Medicare
  - Entitlement program
- Medicaid
  - Welfare program

Balanced Budget Act Programs

- Program of All-inclusive Care for the Elderly (PACE)
  - Care provided in day-care centers, homes, hospitals, nursing homes
- State Children's Health Insurance Program (SCHIP)
  - 1998: 11.6 million children uninsured
  - Additional funding

Military Health Services System

- Active duty
- Dependents
- Retirees
- TriCare
  - Brings resources together

Department of Veterans' Affairs

- Executive department of government
- Tax-financed agency

Indian Health Services

- Direct care for Native Americans on reservations

Payment Function

- Third-party payers
- 2 main facets
  - Determination in advance
  - Determination after services delivered
- Fee schedule
- Claim (bill)
- Reimbursement
- Disbursement

Reimbursement Methods

- Fee-for-service
- Bundled charges
- Resource-based relative value scale
- Managed care
- Cost-Plus reimbursement
- prospective reimbursement
- DRG's
- Resource Utilization groups

Fee-for-Service

- Oldest form of payment
- Physician sets price
- Services are itemized

Bundled Charges

- Package pricing
- Multiple services in one price

Resource-Based Relative Value Scale

- Omnibus Budget Reconciliation Act (1989)
  - Relative values assigned to services
    - Based on skill, time, intensity
    - Adjusted for geographic variations

Managed Care Approaches

- 3 main approaches:
  - Preferred provider
  - Capitation
  - Salary

Cost-Plus Reimbursement

- Rates based on total costs
- Cost report
- Reimbursement related to:
  - Length of stay
  - Services
  - Costs of providing services

Hospital Reimbursement

- 2 mechanisms for reimbursement:
  - Retrospective
  - Prospective

Retrospective Reimbursement

- Amounts are set after services provided
- Based on charges and costs

Prospective Payment Systems

- Payment based on predetermined rates per Diagnostic Related Group (DRG)
- DRG
  - Classification system
  - Payment set per discharge not per diem
  - Rate established for bundled services

Problems in Financing

- Long-term care
- Cost shifting
- Fraud and abuse
- uninsured

In Conclusion