Transcript

Health Care Financing, Part 1

Lecture companion to the text, Chapter 11, “Health Care Financing”

1. This first lecture on Health Care Financing covers public programs, such as Medicare, Medicaid, SCHIP, and other programs. In the next lecture in the module, I’ll present information on private insurers and the payments to healthcare providers and hospitals.

2. The objectives of this presentation are:
   • Describe the magnitude of the U.S. government’s role in healthcare financing
   • Define important concepts in insurance
   • Identify the programmatic parts of Medicare
   • Explain the role of Medicaid
   • Examine the Children’s Health Insurance Program

3. Health insurance fees (or premiums) are paid in advance, this guarantees that money is centralized in a pool that will be there to pay healthcare providers, hospitals, pharmacies, etc. When the money is pooled as a group, the individuals share risk. And, assuming everyone paid the same amount for the health insurance (that is, not dependent on their health status), the healthy individuals financially support the sick. This subsidy is because the healthy use relatively little health care services, and the sick use a lot of health care services, of course. This is a concept that we reviewed in the lecture on the Affordable Care Act. Do you remember what it is called when a disproportionate amount of sick people enroll in a health insurance plan?

4. This chart helps explain the need for healthy individuals to subsidize the sick in a health insurance pool. As you can see on the far right, the healthiest 50% of the population only made up 2.9% of the total health care spending in 2009. Moving one bar over to the left, you can see that the sickest 50% made up over 97% of the costs. In fact, the sickest 20% made up over 80% of the healthcare spending in 2009. So, to keep costs of insurance down for the sickest, the healthy subsidize the insurance pool. In some ways, this may be unfair, especially for populations whose risks of getting sick are very low, such as undergraduate students. On the other hand, even the remote chance of developing a disease or condition needing very expensive treatment may be worth the cost of insurance. Nevertheless, the insurance market cannot work without the healthy subsidizing the sick because of adverse selection.

5. Here is a very simple diagram to explain the health insurance financing process. As you can see, insurers collect premiums from patients and pool the resources. When the patients go to the doctor, hospital, or pharmacy, the insurance company pays them. Also note that the insurance company keeps some money for themselves as profit. Under some circumstances, insurance companies lose money if they don’t accurately predict how much they will have to pay to healthcare providers. Many different entities can act as the health insurer – private insurance companies, non-profits, self-insured organizations (such as large corporations), and the government. Large companies often
self-insure and collect premiums from workers’ paychecks and then pay providers. Also, the
government collects taxes to fund the pool, then they pay healthcare providers. I’ll start by
explaining U.S. government insurance programs.

6. Let’s begin with public programs. As you can see from this chart that I presented in a previous
lecture, the government pays for almost half of health care in the U.S. This includes all of the
government programs, including Medicare, Medicaid, SCHIP, and the VA. We’ll start with Medicare
on the next slide.

7. The Centers for Medicare and Medicaid Services administers Medicare. Medicare is the nation's
largest health insurance program that covers nearly 50 million Americans. Medicare is an
entitlement program. An entitlement program is the kind of government program that provides
individuals with personal financial benefits or special government-provided goods or services that
they have a legal right to whenever they meet eligibility conditions that are specified by the law that
authorizes the program.

8. Medicare is a federally funded and federally run program for the elderly, some disabled, and
persons with End Stage Renal Disease (ESRD). There are four parts to Medicare. Generally, Part A
covers hospital care, Part B covers physician care, Part C created the Medicare Advantage private
insurance health plans, and Part D covers the prescription drug benefit. When I first learned about
the program parts, I thought it was pretty boring. Maybe it is a little, but it is really important to
understand the basics of Medicare in order to have an understanding of our U.S. healthcare system.
So memorize this slide for the sake of your future career.

9. This chart shows the Medicare expenditures by type of services in 2012 and colored by the part of
Medicare that covers the benefits. As you can see inpatient (or hospital) services are the largest
component. A special note. The Medicare Advantage component makes up 23% of the total. I’ll
explain Medicare Advantage more in a bit, but you should understand that the expenses flow
through private companies who then pay providers. This means that this piece of the pie will then
be split out in a similar manner as the rest of the chart. I think this can be confusing to people.
Please let me or the TA know if this is not clear.

10. Medicare Part A. Hospital Insurance helps cover inpatient care in hospitals and skilled nursing
facilities (SNF). There is no premium for beneficiaries that have worked and paid Medicare taxes for
ten years (or forty quarters). Those that have worked less pay a premium of up to $450 month,
depending on how many quarters were worked. Seniors that qualify are automatically enrolled in
Part A on the first day of the month they turn 65.

For each benefit period Medicare pays all covered costs during the first 60 days of a hospital stay,
except the Medicare Part A deductible, which was $1,216 in 2014. Beneficiaries pay some costs for
days 61-149 and then all the costs for 150 days and more. Inpatient hospital costs account for the
majority of Part A expenditures.
• Skilled Nursing Facilities (SNF) are a place for patients who are not sick enough to need hospital care but are not able to remain at home.
• Home health care for eligible beneficiaries requires no deductible or copayments. To be eligible, a beneficiary must be receiving skilled nursing care. Home health includes the same services received at SNFs and also includes durable medical equipment, such as hospital beds or wheelchairs and supplies such as catheters or wound dressings.
• Hospice care is for beneficiaries that have been diagnosed with less than 6 months to live. Hospice care is provided at home, or in a facility with a homelike setting, a hospital, or a nursing home and is referred to as palliative rather than curative care. This care is to alleviate pain and illness in the last months of life. Patients receiving palliative care are not expected to recover.
• SNFs, home health and hospice are preferred alternatives to hospital care, not only to control costs, but for better quality of life for the patient.

11. Seniors can sign up for Part B at the time of Part A enrollment. Since Part B is a voluntary program which requires the payment of a monthly premium, those individuals who do not want coverage may refuse enrollment. Medicare deductible and premium rates are subject to change annually. Most people pay a monthly premium for Part B coverage, which was $104.90 in 2014. The deductible in 2014 was $147 per year. After the deductible, beneficiaries also pay a 20% co-insurance, which means that Medicare pays 80% of the doctor’s bill and the patient pays 20%.

12. The majority of Part B spending is on physician services, and outpatient hospital care. Part B pays for home health care not covered under Part A. The other category, accounting for 21% of Part B, includes durable medical equipment, certain preventive services, and lab tests. The Affordable Care Act adds annual wellness visits at no charge to the enrollee—no deductibles or co-insurance payment obligations apply to wellness visits.

13. Deductibles and copayments, as well as many needed services, are not covered by Medicare. Also, basic healthcare items, such as routine eye care, most eyeglasses, dental care and dentures, hearing aids and hearing exams are not covered benefits. For this reason, many seniors choose to purchase supplemental health insurance.

14. This chart shows that supplemental coverage comes in many forms. They help pay for expenses that Medicare does not cover. Only 12% of beneficiaries don’t have supplemental coverage of some kind. An important supplemental coverage is called Medigap. In 2009, Medigap made up 24% of those with supplemental coverage. Medigap plans are run by private companies, but they are regulated by the government. There are 10 different standardized Medigap benefit packages; each plan pays for a particular set of benefits. Across all plan types, the average Medigap premium was $183 per month in 2010. You can see that many Medicare beneficiaries also have private health insurance through their work. See the Employer-sponsored pie piece on the left is 25%. For those that can’t
afford to pay for both the Part B premium of about $100 per month and the Medigap premium, private Medicare Advantage plans are an option. You can see that 14% of beneficiaries have Medicare Advantage. I’ll present Medicare Advantage next.

15. Part C is now called Medicare Advantage (or just MA). This plan gives Medicare enrollees the option to enroll under a private Medicare plan. MA plans are required to offer the same comprehensive set of services as the traditional Medicare program. As mentioned above, these private insurance companies receive payments from CMS for each MA enrollee. In turn, the MA plans pay the doctors, and hospitals, etc.

MA plans have been chosen by poorer Medicare patients because plans often cover the Part B premium and many copayments and certain additional benefits, such as eye glasses or gym memberships. This makes it more affordable for the beneficiaries than traditional Medicare.

However, the controversial aspect of privatizing Medicare is that the private MA plans are more expensive than traditional Medicare, estimated at costing 13-17% higher.

16. Prescription drugs weren’t offered through the Medicare program until 2006. Part D prescription drug insurance plans are sold and administered by private insurers, such as Blue Cross/Blue Shield and WellCare. Beneficiaries choose their drug plan and pay a monthly premium. The premium depends on the type of plan chosen.

The donut hole (we saw this in the ACA lecture) was created to hold down program costs. The donut hole is a period of time during the coverage year when the beneficiaries will be responsible for paying all the drug costs out of pocket with no contribution from the plan. The Affordable Care Act legislates that this gap in coverage will be eliminated by 2020.

17. As a review, the Medicaid and Medicare programs were enacted in 1965. Both are considered entitlement programs. Medicaid was intended to insure children in low-income families. A major difference between the two programs is that Medicare is completely run and funded by the federal government, whereas, Medicaid is jointly funded by the federal and state governments. To qualify for Medicaid, individuals must meet both income and categorical eligibility requirements. The federal government sets minimum standards of coverage and then the states have the flexibility to raise these levels. States may also set the rates of payments for the services that they choose to provide. Some services are optional, others are mandatory.

18. Medicaid does not provide for all low-income persons, not even for the very poor unless they are a part of one of these listed categories, AND they meet income requirements. The income requirements are determined by the Federal Poverty Level (FPL). The 100% of the FPL for a family of three was $19,530 in 2013.
As you can see in this chart, the eligibility levels are different for different categories of individuals. Children in a household of three people would have been eligible for Medicaid if their family made less than $45,895 ($19,530 x 235%). A single pregnant woman could obtain pregnancy, delivery and postpartum care coverage through Medicaid if she made less than $36,130. As you can see, the other categories have very low income thresholds, and childless adults are not eligible.

However, things are different under the Affordable Care Act Medicaid expansion provisions, IF a person’s state chose to expand Medicaid. The three categories on the right side would be eligible for Medicaid at 138% of the FPL. For example, a working parent part of a family of three that earns less than $24,344 ($19,530 x 138%) could enroll in Medicaid. For the states that chose not to expand Medicaid, the child or pregnant woman would be eligible for Medicaid at that income level, but not the parents.

19. This slide is intended to communicate to you how important Medicaid is to long-term care financing. According to the Department of Health and Human Services, Medicaid “is the single largest source of coverage for nursing home care.” While Medicare covers skilled nursing care recovery from an illness or injury, the federal program does NOT cover long-term care. This is covered by the state-run Medicaid. In fact, Medicaid accounted for 43% of the payments for long-term care in 2011, according to Kaiser Family Foundation.

This chart shows that among the money that Medicaid spends, long-term care users accounted for almost half of the spending, even though they make up only 6% of the Medicaid recipients, according to the Kaiser Family Foundation report.

20. State Children’s Health Insurance Plans is also called SCHIP or just CHIP. CHIP offers coverage to children that wouldn’t qualify for Medicaid due to exceeding the income limit, but not having enough income to purchase private insurance. Florida calls their CHIP program Florida KidCare. Different states structure and administer their CHIP programs differently.

Forty-six states and the District of Columbia cover children up to or above 200% of the Federal Poverty Level (FPL), and 24 of these states offer coverage to children in families with income at 250% of the FPL or higher, according to CMS. Like Medicaid, SCHIP is a jointly financed by the federal and state governments. However, the federal share of the expenditures is higher for SCHIP than Medicaid for each state.

21. Of course, there are other programs for which the government funds and/or administers. Other federal programs include the military services for both those active on duty and those retired. Many of the other federal programs are run by agencies within the Department of Health and Human Services, such as the National Institutes of Health. The state governments fund health care and insurance. For example, Delaware used tobacco settlement funds to pay for care with participating providers for uninsured people up to 200% of FPL. Local governments provide health insurance benefits, also. For example, the Hillsborough County HealthCare Program provides comprehensive
managed care to those up to 100% of FPL who are not eligible for another plan. The plan is paid for
by allocating property tax revenues intended to reimburse uncompensated hospital and by sales tax.

22. In conclusion, the government plays large role in health care financing. Medicare is a federally
funded and federally run program for aged and disabled. Medicaid is a federally and state funded
program RUN by each state for low-income people. SCHIP is a federally and state funded program
run by the states for moderate income children.