1. This second lecture on Health Care Financing covers information on healthcare spending growth, private insurers, and the payments to healthcare providers and hospitals. This is a lecture companion to Jonas & Kovner’s Health Care Delivery in the United States, Chapter 10, “Health Care Financing.”

2. The objective of this presentation are:
   - Understand U.S. health care spending over time
   - Understand employer-based health insurance
   - Describe healthcare payment models
   - Compare incentive types among providers and patients

3. Overall healthcare costs have been increasing steadily for over 50 years, for multiple reasons. This chart shows the increasing per person national health expenditures in the United States. It also shows, at the bottom, the increasing share of our health spending relative to the gross domestic product, which is the measure of all dollars spent in our government.

4. This figure shows the many drivers of healthcare cost increases in the United States. You won’t be tested on the details of this figure, called an Ishikawa or fishbone diagram. You should know the direction of the trend of healthcare spending in the United States over the last 50+ years.

5. Unfortunately, we have little to show for our increased spending in terms of quality outcomes. This is an example of a specific health outcome – percent of women age 45 that live to be 60 years old. As you can see, the survival rate for this group has increased throughout the world since 1975, and it came with a cost. As you can see, all of the countries’ spending have increased in the thirty years of this chart. However, please note that the costs to the United States for the modest increase in survival rates is much more significant than the rest of the world.

6. Maybe there is good news after all. From 2000 through 2008, spending grew by an average of more than 7%, and it grew by double digits in the previous decade. However, in 2012 healthcare spending only increased 3.7% from the previous year. (The percentage of GDP is stable.) The cause unknown. Some suggest that the “Great Recession” was the biggest cause, but this factor’s contribution to the slowdown is not known at this time.

7. Let’s take a look at the types of health services we are spending our money on in the U.S. First of all, we spend most of our resources - 83 percent - on personal health care. Public health activities, associated with preventative services, was only 7% of our U.S. health expenditures. To put that in context, in the late 1990s, we spent $4,000 per capita per year in personal healthcare, but only $44 in public health per capita (Eibert, K., 1996, Measuring expenditures for essential public health. Public Health Foundation).
8. Looking more closely at our personal health care expenditures, the majority come from hospital and physician services. This chart is from the Kaiser Family Foundation.

9. Now let’s transition to looking at private health insurance. This chart shows the decrease in enrollment in private health plans until the passage of the Affordable Care Act in 2010. Following the ACA, the number of uninsured decreased and private insurance increased as people signed up through the Health Insurance Exchanges.

10. This slide from Kaiser Family Foundation shows the increase in health insurance premiums over time. A high premium for workers is an important reason for controlling health care costs. Health insurance is unaffordable for many individuals and families.

11. The first type of plan listed is fee-for-service (FFS), also known as conventional or indemnity insurance. This plan is available in the private market and is not effective in controlling costs.

Next are Health Maintenance Organizations (or HMOs). HMO enrollees receive most or all of their care from a network provider, in other words, a provider that has contracted with the insurance company’s network. HMO rules require the choice of a primary care physician (PCP) who is responsible for managing and coordinating all health care. If you need care from a physician specialist in the network or a diagnostic service such as a lab test or x-ray, the PCP must refer you. An HMO PCP is called a “gatekeeper” in this managed care structure.

A Preferred Provider Organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. You do not need to select a primary care physician (PCP) and you do not need referrals to see other providers in the network. If you receive your care from a doctor in the preferred network you will only be responsible for your annual deductible and a copayment for your visit. If you get health services from a doctor or hospital that is not in the preferred network you will pay a higher amount.

A point-of-service (POS) plan is a mix between an HMO and a PPO. Typically, POS plans have a network that functions like a HMO – you pick a primary care doctor, who manages and coordinates your care within the network. POS plans also allow you to use a provider who is not in the network. However, if you choose to go out-of-network for your care, you will pay more.

A high deductible health plan (HDHP) is a type of health insurance plan that requires greater out-of-pocket spending, although premiums may be lower. Health Saving Accounts (HSA) can be used with HDHPs. Earnings are deposited into an HSA and are not considered part of taxable income. These earnings can be used to pay for qualified medical expenses.
12. Health insurance companies pay health care providers in a variety of ways. Fee-for-service is the system of payment where the provider bills the insurance company for each service they provide, such as a doctor’s visit. That is, they get a fee for each service.

Diagnostic related groups (DRGs) were created to improve hospital efficiency and to control rising health care costs. Since 1983, hospitals have been paid on a fixed amount basis based on DRGs for every Medicare admission. DRGs are conditions that are grouped based on similar costs, such as heart failure.

As mentioned above, insurance companies often choose to reimburse hospitals per day. The reason is that the first day is the most resource intensive and therefore most expensive. Most of the laboratory tests and imaging tests are run on the first day. The per diem rate takes the financial risk away from the payer if providers over-utilize testing and other services.

Capitation payments are paid to providers in the form of one monthly payment for each patient’s treatment for that month—called per member per month (PMPM). This method is closely associated with managed care plans. It doesn’t matter how many times or how many services a patient receives in a month, the provider will only get paid the PMPM fee. This means that a provider receiving the capitation would have an incentive to keep the patient healthy so that they used less healthcare.

Global (or bundled) payment system is a lump sum for a defined episode of care. It is similar to capitation in that it is a lump sum, but different in that it is a fee for a provided service. An example of a bundled payment is newborn delivery – the doctor would get paid the same whether the delivery was vaginal or cesarean.

13. For private insurers and the uninsured, each hospital has its own charge master with a list of services and their charges. Consequently, across hospitals in a given state, the list price for a particular item, e.g., a normal chest X-ray, can vary tenfold or more. Private insurers rarely pay the full charges, but rather, negotiate discounts. Unfortunately, the full charges often get billed to the uninsured who have little negotiating power.

Annually establishing the prices that a given insurer will pay a particular hospital and the prices charged the uninsured is an enormously cumbersome and highly labor-intensive process not used by any other health system in the industrialized world. It adds a significant component to the high administrative cost that is unique to the American health system. One interesting aspect of this process is the wide variation in how much a basic medical service costs at different hospitals, a variation that does not appear to be tied to quality of care.

Hospitals charge Medicare using DRGs with payments determined by CMS, there is no negotiating with CMS. DRGs are assigned using the International Classification of Disease (ICD-9) system created
by the World Health Organization (WHO). Payment amounts for each DRG are based on the average resources used for those ICD-9 codes within that DRG group.

In some states, such as Florida until July of 2013, hospitals are paid for each night a patient stayed, called0 “per diem.” These rates vary by hospital and are based on costs of providing care.

Physician services are not part of the hospital bill.

14. Retrospective payment means that hospitals would charge Medicare based on the total cost of treating the patient, after they were treated. If hospitals were inefficient in treating patients by keeping patients in the hospital beyond a required length of stay, then hospitals were paid based on the total cost generated. Because of this type of billing, health care costs increased rapidly.

As a result of this phenomenon, diagnostic related groups (DRGs) were created to improve hospital efficiency and to control rising health care costs. Since 1983, hospitals have been paid on a fixed amount basis based on DRGs for every Medicare admission. DRGs were further refined in 2008 by adding risk adjustment, also called adjusting for severity of illness, to account for patients with major complication and comorbidities (MCC), non-major complications and comorbidities (CC) and those without complications or comorbidities (non-CC).

Beginning in 2008, a “present on admission” field was added to the patient medical record. If a patient incurred certain hospital acquired infections, they won’t be reimbursed for that treatment, beginning in 2013. Also beginning in 2013, Medicare will begin applying penalties to hospitals that have high readmission rates for certain conditions. Readmission refers to patients being admitted to a hospital within 30 days of discharge for the original admission.

15. Physicians use Current Procedural Terminology (CPT) codes for billing Medicare. The American Medical Association (AMA) has a committee that advises CMS on new and revised physician medical, surgical and diagnostic procedures so the list of CPT codes is constantly updated. CPTs accomplish the same task as DRGs, providing a uniform coding system for providers, medical coders, and payers to use, but CPTs focus on the procedure rather than the diagnosis. The S codes are used to charge for a series of procedures under one code. The S codes were developed by CMS.

Resource-Based Relative Value Scale (RBRVS). A payment system is based on a national fee schedule that assigns relative values to services based on work value, expenses, malpractice risk and geographic adjustments. For example, it’s more expensive to provide services in Manhattan than in a smaller city.

16. Incentives play a vital role in the behavior of patients and providers as they adapt to the changing market. In a fee-for-service system, the incentive for the provider is to perform as many services as possible. This increases the cost for our healthcare system. On the other hand, capitation pays for doing as little as possible. This reduces quality and frustrates patients and providers, alike. There
have been experiments to combine payment with quality, called pay-for-performance (or P4P). The results are mixed. One big problem is the measurement of quality of healthcare is imprecise.

17. According to the RAND publication, the RAND health insurance experiment was started in 1971 and and largest health policy study in U.S. history, even to this day. The key finding of the 15 year study was that patients in a group that paid for a share of their health care used fewer health services than a comparison group given free care. The cost sharing reduced both effective and ineffective care in equal measure. In general, there was no difference in health outcomes. Although, the exception in outcomes was found among the sickest and poorest patients who had worse outcomes when cost sharing was used.

The common cost sharing elements in health care in the U.S. are co-pays, co-insurance, and deductibles. A co-pay (or copayment) is the amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or a prescription. The co-insurance is an amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%). Finally, a deductible is the amount you must pay for health care or prescriptions before your insurance begins to pay the bills.

Private insurers use cost sharing as financial disincentives in order to reduce unnecessary care. For example, a person with a deductible and co-pay may think twice about going to a doctor at the first sign of a cold. The concept in insurance where people use more care when it is free is called moral hazard.

18. The last fifty years have seen increasing cost of care and increasing cost of health insurance. These have placed an ever increasing financial burden on the U.S. economy. Financial incentives are directed at both payers and consumers. Incentives play a vital role in the behavior of patients and providers.