Financing Health Services
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Health Policy & Management

PHC 6102
Principles of Health Policy and Management
Part 2 of 2

1965
Increasing role of federal government

• Original Medicare
  – Federal program
  – Title 18 of the Social Security Act
  – Provides coverage for elderly and disabled
  – Two Parts - Part A and Part B
    • Parts C and D were added later
• Medicaid
  – State programs with federal matching funds
  – Funding for poor

MEDICARE
• Universal Entitlement Program
  – Provides same benefits to all
• Medicare Eligibility
  – U.S. citizens or permanent residents ≥ 65 years old AND
    – Individual/Spouse worked >10 years in Medicare covered employment
  – Alternative Eligibility (< 65 years old)
    – Kidney dialysis or kidney transplant patient or
    – Received Social Security disability benefits for 24 months

MEDICARE: Part A
Predominately for Institutional Care
• Hospital inpatient care
  – 90 days maximum per year
• Skilled nursing care (rehabilitation)
  – 20 days paid per year
  – Days 21-100 partial payment per year
• Home health
• Hospice

MEDICARE: Part B
Predominately Professional & Outpatient Services
• Physician services
• Hospital outpatient services
• Emergency room visits
• Ambulance transportation
• Laboratory and diagnostic tests
• Mammograms and Pap smears
• Outpatient therapy services
• Durable medical equipment

Funding Medicare Parts A & B
• Part A Hospital Insurance
  – Funding - Payroll taxes
  – Deductible = $992 (www.medicare.gov)
• Part B Medical Insurance
  – General revenues (federal govt. subsidy)
  – Premium (varies by income)
    • $115.40 to $369.10 monthly
    • Voluntary - requires premium payment
  – Deductible = $162
  – 20% coinsurance
**Medicare Services Not Covered by A & B**
- Dental care or dentures
- Nursing home custodial care
- Eye care or eyeglasses
- Hearing aids
- Routine physical exams
- Transportation
- Prescription drugs (now optional under Part D)

**Medicare Part C (optional)**
**Medicare Advantage**
- Health plan offered by a private company (such as an HMO or PPO) that contracts to provide a member’s Part A and Part B services
  - Some also include Part D
  - Option enacted in 1997
- Services are paid by the health plan and not by original Medicare
- Can join during enrollment period

**Medicare Part C**
**Managed Care**
- Combines financing & delivery of health care
- Entity is interposed between patient and physician
- Health plan can constrain how and from whom patients receive health services

**HMOs**
**COST & UTILIZATION CONTROLS**
- Provider panel
  - Must use for HMO payment coverage
- Negotiated fees
  - Apply for all services
  - Gatekeepers
  - Authorizations for Service

**PROVIDER PANELS**
- Cost-efficient providers who accept terms
- HMO & provider agree to terms & sign contract
  - Clinical services to be provided
  - Reimbursement terms
  - Service standards (e.g., waiting times)
  - Contract cancellation provisions
- Different terms used for primary care, specialists, hospitals

**Negotiated Fees**
- Health care providers establish prices
  - Then, HMO negotiates discounts
- Wide range of payment methods exist
  - Fee schedule
  - DRG or per diem for hospitalizations
  - Capitation
Gatekeeper Physician

- Physician responsibilities:
  - Provide basic services to patient
  - Determine & coordinate other services provided for patient (hospital, specialist, dx)
- Goal - Keep services at lowest level of care

Authorization for Services

- Required for certain services (admission, surgery)
- Granted by the HMO
- No authorization = provider does not get paid

HMO versus PPO

<table>
<thead>
<tr>
<th>HMO (Health Maintenance Organization)</th>
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<tr>
<td>• Provider panel - must use for HMO payment</td>
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<tr>
<td>• Negotiated fees apply for all services</td>
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<tr>
<td>• Gatekeepers</td>
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<table>
<thead>
<tr>
<th>PPO (Preferred Provider Organization)</th>
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</thead>
<tbody>
<tr>
<td>• Provider panel - use is optional</td>
</tr>
<tr>
<td>• Negotiated fees - also cover non-panel</td>
</tr>
<tr>
<td>• No gatekeepers</td>
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Medicare Part D

Part D Prescription Drug Coverage (Optional)

- Enacted in 2003 (implemented in 2006)
- Recipients can select a prescription drug plan
  - Stand-alone drug plans offered by private insurance companies
- Most plans charge a premium, which varies by plan
- May require cost sharing
- Costs and coverage varies by drug plan
- Can only enroll or change during specific time periods

Medicare

- In current health reform efforts, elderly are asking that Medicare is not impacted by reform
- Patient Protection and Affordable Care Act of 2010
  - Slows the growth in Medicare spending by $400 billion from 2010 to 2019
- Medicare - 15% of the federal budget

Medicare

- Title 18 of Social Security Act
PASSAGE OF ORIGINAL MEDICARE

• Enacted in 1965
  – After many years of emotional discussion
  – Many compromises
  – Battle of economic interests
  – Controversy: cover all elderly or poor elderly?
• Controversial, yet prevailing concepts
  – Eligibility based on age
  – Program financed through Social Security taxes

THREE-LAYERED CAKE
Signed into Law July 30, 1965

• Layer 1 - Democratic plan for compulsory hospital insurance under Social Security (Part A)
• Layer 2 - Republican plan for government subsidized voluntary insurance to cover physician services (Part B)
• Layer 3 - Expanded assistance to states for medical care to poor (Medicaid)

MEDICAID

• Also enacted in 1965
  – Program for low income individuals and families of all ages
  – Continuation of previous welfare medicine programs
  – Financed from general taxes at both state and federal levels
• Administered by states
  – States establish eligibility criteria & benefits

MEDICAID PROVISIONS
States design programs

• States must comply with federal guidelines
• Income-Related Program - Means Test Applied
• State Decisions
  – Generosity of Benefits
  – Method Used to Implement Means Test

Medicaid Eligibility

• Restricted to persons in specified categories
• Categories include:
  – Pregnant women
  – Children and teenagers
  – Aged (65 years of older)
  – Blind or disabled

Percent of Births Covered by Medicaid

• Louisiana – 63%
• Florida – 55%
• California – 46%
• Iowa – 32%
• New Hampshire – 23%
Aged, Blind, or Disabled

- Eligibility requires have low income and few resources
- Apply if living in nursing home
- Apply as dual enrollment with Medicare

Medicaid

Title 19 of Social Security Act

http://www.ssa.gov/OP_Home/ssact/title19/1900.htm

Centers for Medicare and Medicaid Services (CMS)

- CMS monitors and maintains records regarding government supported health care programs
- Programs include:
  - Medicare
  - Medicaid
  - S-CHIP
- Formerly know as HCFA (Health Care Financing Administration)

State Children’s Health Insurance Program (S-CHIP)

- S-CHIP offers states three options when designing a program. A state can:
  - Use SCHIP funds to expand Medicaid eligibility for children who previously did not qualify for the program, or
  - Design a separate child’s insurance program, or
  - Combine both the Medicaid and separate program options

Health Insurance Status of Total Population 2013

Uninsured by Race Ethnicity: 3 Year Average 2008-2010

U.S. Census Bureau

- Non-Hispanic White: 11.2%
- American Indian/Alaskan Native: 28.1%
- Asian: 17.2%
- Pacific Islander: 18.4%
- Black: 19.9%
- Hispanic: 30.7%

Source: http://kff.org/statelab/
Health Reform
Patient Protection and Affordable Care Act of 2010

- Individual mandate to purchase insurance
  - If not, required to pay fine
- Rationale
  - Insurance companies cannot discriminate (deny coverage) on pre-existing conditions
  - If no mandate, patient could wait to become ill to purchase insurance
  - Can pay the fine and then purchase health insurance once becoming ill

Public Option

- Public insurance plan
  - Similar to Medicare
  - Means of assuring affordable health care
  - Would have lower administrative costs
  - No allocation of revenues to "profit"
- Without public option, forced to purchase insurance from private companies

Example of Allocation of Health Plan Revenue

<table>
<thead>
<tr>
<th>Medical Cost as % of Revenue</th>
<th>80%</th>
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<tr>
<td>Administrative Cost</td>
<td>15%</td>
</tr>
<tr>
<td>Profit</td>
<td>5%</td>
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TIGHTWADs

<table>
<thead>
<tr>
<th>% REVENUES FOR MEDICAL COST</th>
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<tbody>
<tr>
<td>$ Health Plan #1</td>
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<td>$ Health Plan #2</td>
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<td>$ Health Plan #3</td>
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<td>$ Health Plan #4</td>
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<td>$ Health Plan #5</td>
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McCarran-Ferguson Act of 1945

"created a statutory exemption for the business of insurance when it is regulated by state law and does not constitute coercion, boycott, or intimidation. The U.S. Supreme Court has taken a restrictive view of what constitutes the business of insurance entitled in the exemption...The court limited the exception to the business of insurance and not the business of insurers.

Government Accountability Office (GAO) Report, 2005

"However, some experts believe that under some circumstances joint trending might constitute price fixing absent the McCarran exemption, and that standardized risk classifications and products might restrict new insurers or products from entering the market, thus limiting innovation, consumer choice, and competition."
Health Reform Victories for Insurance Companies

- No public option
- McCarran-Ferguson not repealed

Part 2 Questions

1. How does eligibility and funding for Medicare and Medicaid programs differ?
2. What are the provisions of Medicare’s Parts A, B, C and D?
3. How does an HMO differ from a traditional health insurance plan?
4. What categories of persons have traditionally been eligible for Medicaid?
5. What political conditions existed in 1965 that allowed for the passage of Medicare and Medicaid?
6. How might a public option advantage the public?