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**AN OVERVIEW OF
THE UNITED STATES
HEALTH FINANCING SYSTEM**

By

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Summary

This paper is an overview of the health financing system in the United States. It begins by reviewing the breakout of insurance coverage within the health care system followed by where Americans obtain their health insurance coverage. Subsequently, there is a short discussion of health insurance companies and health benefits plans. A large segment of the paper is devoted to an explanation of the various types of cost control measures developed for health benefits plans over the past two decades in response to large cost increases. These include utilization management systems, preferred provider organizations and health maintenance organizations. The paper concludes with a brief review of some of the advantages and disadvantages of the US health financing system.

Health System Insurance Coverage

The American health care system is financed through the participation of multiple payers. Participants are both public and private organizations. The private organizations may be either profit or not for profit. Sixty-two per cent of Americans are covered by employer sponsored health insurance. Government covers 19% of Americans. The government program for older people called Medicare covers 12% and another 6% use a different government program for poor people called Medicaid. A small fraction of people have coverage through a government run veterans program. Six per cent of Americans purchase their own health care coverage. Finally, 14% have no insurance coverage at all. These people, the uninsured, have to pay for health services from their own resources.

Employer based health benefits plans cover a large portion of the American population. Health insurance is funded through health insurance premiums that are paid in combination between the employer and employee. All health care providers are available for care. However, in recent years, new health insurance product offerings have been limiting the availability of all providers through their managed care initiatives. Health insurance companies that sell health benefits plans to employers are regulated by state insurance departments. Each of the fifty states creates their own set of regulations. Insurance companies that wish to sell insurance in all fifty states must be approved and abide by each state's regulations. The regulations deal with fiscal solvency of the insurance company and establish minimum health benefits coverages. In general, employer based plans incorporate deductibles, coinsurance payments, out of pocket maximums, and life time maximums into their coverages. Providers are paid their charges on a fee for service basis meaning for each unit of service performed. The usual payment mechanism is for the patient to pay the physician and submit a claim to the health insurance company or the administrator of the health plan and receive reimbursement. Hospitals usually bill the insurance plan or claims administrator directly.

Medicare is a federally regulated program that is funded by a tax on employers and employees and participant premiums. The program is for all Americans aged 65 years or older and a small number of disabled. Coverage is for a federally defined set of services- currently encompassing hospital services, skilled nursing facilities, home health agencies and physician services. Coverage is not 100%, but includes deductibles, coinsurance amounts and day limitations. Coverage can be sought at any Medicare participating provider. These providers

have to meet certain regulatory requirements. Virtually all acute care medical surgical hospitals participate, but a more limited number of physicians participate. Hospitals are paid on the basis of diagnostic related groupings. These are diagnostic based categories that are grouped by similar resource usage. Hospitals have to accept the Medicare payment as payment in full and not bill the patient for anything other than deductibles and coinsurance. Physicians are paid by Medicare at 80% of the physician's usual and customary charge. Physicians who agree to accept assignment are not allowed to bill the patient for the difference between the physician fee and the Medicare allowable fee. Other physicians will bill the patient for the difference (called balance billing). Insurance claims are processed by fiscal intermediaries contracted by the Medicare program to handle the administrative functions.

The federal government also operates another health program called Medicaid in collaboration with the states for low income (poor and disabled) people. Within broad parameters the federal government defines certain eligibility and services to be covered. The states can adjust eligibility and coverages as they see fit within regulations. The services covered include hospital, physician, skilled nursing facilities, and others that are chosen by the state. There are no copayments for the Medicaid patient. Nationwide, the federal government pays for approximately 56% of the costs and funds the program through a payroll tax. The actual federal participation for each state is set by the federal government based on established economic indicators. State funding is from their general revenues. Medicaid recipients can only go to Medicaid participating providers. Like Medicare most of the institutional providers participate, but physician participation is very limited. Medicaid payments are set by each state. Some states have elaborate rate setting bureaucracies while others establish charge limits, day limits, or fee schedules. Providers have to accept the Medicaid payment as payment in full. No balance billing is allowed. Health care providers feel that both government programs do not cover their costs for providing a service. Medicare is felt to do so more adequately than Medicaid.

For approximately 800,000 veterans of the U.S. armed services, their health care coverage is handled by the federally operated veterans health care system. This government operated health care provider system includes ambulatory clinics and acute care hospitals. Health care providers are paid government salaries. The system is funded through general revenues of the federal government. Non-veterans are not allowed access to the veterans facilities.

Some Americans purchase health insurance plans directly from insurance companies. These people are usually self-employed or work at a company that does not offer health insurance. Individual health plans are usually not very comprehensive either in services or dollars covered. These plans may be difficult to obtain. Insurance companies usually require a medical review of each applicant (a practice known as medical underwriting). Individuals with a current illness or who are at high risk for an illness may be denied coverage. Or, a policy may be written with exclusions to eliminate coverage for preexisting conditions.

The 34 million uninsured are a mixture of individuals. Sixty per cent are poor or near poor with family incomes at or below two times the federally established poverty level. Four and a half million people, or 14% of the uninsured, are self-employed. Only 6% of the uninsured are unemployed leaving 80% of the

uninsured employed. Only 16% of the employed uninsured work for companies of more than 100 employees. Nineteen percent work at companies of 26-100. Twenty two per cent work at companies of 10-25 employees. The largest portion of the working uninsured ,44%, work at companies of less than 10 employees. Small companies feel they cannot afford the exorbitant rates insurance companies charge for the coverage and remain in business.

Though the uninsured have no insurance coverage, this limits their access to care, but does not eliminate it. Some pay for care out of their own pocket as it is incurred. Many use services provided at no charge at facilities run by state and local governments funded through their general revenue sources. Unfortunately, these services are usually viewed as being of substandard quality and not as technically advanced. Physical plants are often old and run down. In times of emergency, private hospitals and many physicians will attend to patients. Federal funding of hospital construction in the 60s yielded requirements for hospitals that received these funds to treat a number of indigent patients at no charge. Non profit institutions also deliver a portion of their business as charity care (free or reduced charges). However, the combination of charity care and underpayment by government programs creates an increment of health care provider charges to insured health benefits plans. Prices are increased to an amount greater than the actual costs for providing the service so as to receive increased reimbursement from those insurance plans or individuals who pay full charges on a fee for service basis. This is a phenomenon known as cost shifting.

Source of Health Insurance

Private insurance coverage is usually purchased through one's workplace. Practically all employers with more than 100 employees offer at least one health insurance option. Even in companies of 25-49 and 50-99, 85% and 89%, respectively, offer health benefits coverages to their employees. As mentioned above, it is the smaller companies that do not offer health insurance. Seventy three per cent of employers with 10-24 employees and just 27% of the 1-9 employees provide health benefits plans.

Another possibility for some employees is to purchase health care from their union. These plans usually are negotiated with the employer to obtain a contribution towards the cost. Or they may be completely independent in terms of plan design dependent on the resources of the union plan.

Employees and individuals may also have the option of purchasing their health insurance from an association or trade group. These plans are usually comprised of people of a similar background (doctors, lawyers, alumni of a college, etc.) or similar businesses. The professional association or organization representing multiple employers enters into a contract with an insurance carrier. Solicitation of participants may be done by the insurance carrier or contracting organization.

Individual health insurance is purchased from an insurance agent or broker to help him identify the plan that best suits his purpose. Individual plans are also available through special non-profit plans regulated by the government but independently operated called Blue Cross Blue Shield. In exchange for their

unique health care organizational status the plans are allowed a special discount on services but usually in exchange for the provision of a community plan to cover uninsured individuals.

Many people have more than one health plan for coverage. They may purchase individual plans as additional insurance to cover the copayments their first plan does not cover. Alternatively, they may be covered by their spouse's health plan. Medicare supplemental plans are also a large market. When one individual has more than one coverage rules need to be established to determine the financial responsibility of each plan. These coordination of benefits rules can be very complex.

Health Insurance Companies

The health insurance system has about 1,200 companies that sell some type of health insurance. The companies each develop their own target markets and the products that they feel will best answer the needs of their customers. The health insurance industry is broken down into segments that cater specifically to certain types of employers. Usually this is expressed in terms of size. Insurance companies may target handling employers of a thousand employees or greater. The needs of the large employer are very different than the needs of the smaller employer. Larger employers usually have multiple locations across the United States meaning separate work forces that have different concepts perhaps of what they want for medical benefits. Medical practices are also different by location. (In the U.S., health care utilization for similar procedures varies by geographic area.) In this environment, the employer attempts to keep the health benefits consistent across the various areas so as not to show favoritism and to ease administration of the overall plan. Thus the large employer creates unique demands associated with sheer volume of services and complexities of administering benefits uniformly.

Other insurance companies may target smaller sized employers. This can be a particularly volatile field as these employers are very sensitive to health insurance premium price increases. In the smaller employer markets there are numerous competitors, but the opportunities may lessen for any one employer. Due to the smaller numbers involved in these groups it is difficult to actuarially rate their experience. Small groups are more likely to experience moral hazard (the tendency to overuse health services) and adverse selection (the likelihood that a group is biased towards sicker individuals). Consequently, these employers are more likely to be subject to medical underwriting or preexisting coverage exclusions.

Marketing is a significant portion of the health insurance sector. Employers can deal directly with the health insurance company through their sales agents or purchase health care through brokers. Brokers represent multiple insurance companies and try to match an employer with the best possible insurance plan. Brokers remain biased to a select number of insurance companies. Benefits consultants are less tied to insurance companies and objectively analyze health care experience and suggest health benefits options for their employer clients. In this way each employer need not have to be current in all the latest health benefits laws and innovations in product design. Agents are also used by individuals directly purchasing private insurance.

Health Benefits Plans

Employers and employees share in the cost of the health benefits plan. Contributions of employers and employees are not taxed by the government. The actual participation rates are determined by the employer. An employer can purchase insurance or decide to self-insure. When self-insuring, an employer avoids the costs of an insurance product (premium taxes, administrative costs and insurance company profit) and the health benefits plan coverage mandates of state insurance departments. The employer funds the health benefits plan expenditures of their work force from operating revenues on a pay as you go basis. A company thus assumes the risk that they will have enough cash for their health expenditures. Unexpected expenditures can seriously erode the financial position of a company if not appropriately planned for. For this reason, employers may purchase stop loss insurance to insure against large unanticipated losses. Self-insured employers may also purchase financial services from insurance companies. Insurance companies and other organizations also market administrative services, such as claims processing, to self insured employers.

Employers devise a health benefits strategy that is consistent with their valuation of their employees tempered by their ability to finance the costs. Acute care coverage is common. In the 60s the trend was to increase the coverage to include first dollar coverage and to expand the services that were offered- psychiatric care, prescription drugs, new procedures, dental services, etc. Recent trends have been a struggle to reduce coverage due to escalating costs while attempting not to demoralize staff and productivity. When projected health plan costs are too large for an employer to support, an employer has the option to pass the increased cost on to consumers of their products, to reduce the wages of their employees, increase the employee contribution to the premium, or increase employee cost sharing in the plan. A majority of the labor negotiations of the past years have centered around the provision of and employer contributions towards health benefits. Employers are feeling unable to fund rich benefit plans while employees want to maintain their insurance coverage at historical levels. As employee financial participation levels increase, there is an increasing fear by employees that they will lose access to care or suffer a lower standard of living.

Most employers offer more than one health benefits option to their employees. These options include a standard indemnity plan (fee for service), an indemnity plan with managed care programs and/or a health maintenance organization. Some employers provide a large number of options. For example, the federal government offers over 200 different options nationwide with an employee in the Washington, D.C. area faced with a choice from 26 different health benefits plans. As the number of options increases there are more administrative needs for the employer. Most employers hire a health benefits administrator to explain and administer each of the different plan options. Employees are given their choice of health benefits options when they first join the company. Employers also offer current employees the ability to shift between health benefits options through an annual re-enrollment period. On a daily basis, the health benefits administrator is responsible for ensuring the equitable operation of the plan and that paid benefits are consistent with stated benefits and regulations.

Health Benefits Cost Controls

Insurance companies have addressed employer cost increase concerns through the development of a series of cost control measures known today as managed care. These measures are incorporated into health benefits plans by creating benefit differentials based on whether the care was medically necessary or not. They usually require some third party review or involvement in the decision to obtain care.

The first managed care options started as simple programs that required second opinions for certain surgical procedures that were believed to be over utilized. Thus, the benefit plan would list a procedure, e.g., open heart surgery, as requiring a second opinion. To receive full benefits for this procedure the patient would have to go to another cardiac surgeon to obtain a professional opinion of the need for the surgery. The insurance company would arrange to have a list of other physicians to go to, establish a procedure for receiving the report of the second physician and pay for the consultation. Other types of programs included limiting emergency room benefits to a dollar amount in line with an office visit if the emergency room of a hospital was used for a non emergency service. Pre-admission testing rules stated that tests done within two days prior to a hospital admission on an outpatient basis would not be reimbursed again when repeated in the hospital on an inpatient basis. Weekend admissions were not covered as treatment was rarely initiated on a weekend day. Finally, pre-certification programs were created that attempted to limit the entry of a patient into the hospital. Each time an admission to a hospital was contemplated the physician was required to call a central phone number where reviewers (usually nurses) given the patient's age, sex, diagnosis and proposed treatment plan would evaluate whether the admission was medically necessary using established standards maintained in manuals or computer systems. Physicians who disagreed with the reviewers' determination were given an appeal mechanism that would entail a physician. Failure to obtain approval would lead to reduced or no coverage by the plan.

The early pre-certification programs have evolved into utilization management programs that incorporate all the separate programs. Second opinions, preadmission testing and weekend admissions are handled through the pre-certification process. Once a hospital stay is approved it receives a set number of days. Utilization management systems follow the patient in the hospital with concurrent review which monitors the patient's status to determine if the stay limit should be altered due to a change in medical conditions. For medical stays that have been completed, the utilization management program performs a retrospective review. The medical chart is obtained from the hospital and medical necessity is determined by the reviewer. Insurance companies also use the medical chart to perform a medical bill audit that matches charges with the medical records to identify any hospital billings that are inappropriate. Though successful in reducing hospital lengths of stay, utilization management programs have created controversy over whether their surveillance is appropriate and frustration with the administrative demands placed on physician offices and hospital staff.

Utilization management programs attempt to control the number of services provided. To control the unit cost of any health care service the preferred

provider organization (PPO) was created. A preferred provider organization can be a profit or nonprofit corporation. Many insurance companies sponsor PPOs while others are independent organizations. A PPO contracts with health care providers for a reduced rate in exchange for providing PPO participants (patients covered by the PPO) increased benefits when they obtain services from the preferred provider. Thus, an incentive is created through a lower out of pocket payment by the patient to use the preferred provider. Due to the increased volume of business, the provider is willing to reduce his normal fee figuring that the increased volume will offset any loss. Indeed the preferred provider should have an increase in income. The PPO has to market the preferred provider network to various purchasers. Purchasers include employers, unions, trade associations and insurance companies. An employer with a group insurance plan can obtain a preferred provider network from their insurance company or purchase directly from an independent PPO. PPOs are usually sold in conjunction with a utilization management program. An employee is offered the PPO as a benefit option at the time of health benefits enrollment. Once enrolled in the plan he has the choice each time he needs to obtain health services to decide if he wants to use a preferred or non-preferred provider. The decision will affect the extent of his out of pocket payments. The key marketing feature of the PPO is this freedom to choose.

PPO providers are reimbursed on a variety of options dependent upon the individual negotiations of each relationship. In general the larger the entity doing the contracting the greater the amount of business they represent to the provider the more advanced the reimbursement methodology. Hospital reimbursement options include a simple discount off of charges, per diem rates (an all inclusive amount by day), case rates determined by treatment category, or DRGs. Physicians can be paid at full charges, discounts, or fee schedules. More mature arrangements include risk sharing with the providers. Risk can be shared through withholds or capitation. A withhold system keeps a portion of the rate which is paid at the end of a reconciliation period based upon utilization performance. With capitation the provider is paid on a per covered individual rate that does not change no matter what the level of health care utilization. It is felt that capitation rates eliminate the tendency to over use health services noted in fee for service systems.

Preferred provider networks have to cover the entire spectrum of physician specialties within a defined geographic coverage area. The number of participating providers is limited. Providers will not provide reduced rates if every provider is contracted. PPOs also have difficulties in contracting with providers to handle all services especially in anesthesiology, radiology, and pathology. To meet the PPO's lower cost objectives, providers' practice patterns are evaluated for cost effectiveness and quality. This is usually done by analyzing a large data base and creating a quality measure from publicly available information. Some approaches to evaluation include professional certifications from medical organizations, hospital length of stays, staffing levels, and other such measures. A key part of any PPO is to maintain an adequate data base to evaluate and report on the savings and success of their network. Employers want to know if their purchase of the PPO network has been beneficial. PPOs want to be sure that they have selected the cost effective providers without sacrificing the quality of the care delivered.

The PPO was a response to the development of a health care organization regulated under a separate set of state regulations called the health maintenance organization (HMO). An HMO represents a merger of a health care financing mechanism and a health care provider delivery system into the same organization. The HMO assembles their provider network in three major fashions. The first is to hire the physicians and ancillary health personnel as employees and pay them a salary (staff model). The salary is independent of the number of patients seen in contrast to fee for service medicine. Another approach is for the HMO to contract with several large multiple specialty group practices (group model). (These are physicians of different specialties who have formed a corporation or partnership to deliver health services.) Finally, an HMO can contract with a series of individual physicians (Individual Practitioner Model, or IPA) who choose to have only a part of their practice with HMO patients. Reimbursement to physicians in the HMO generally is by capitation for the primary care physician and either capitation or reduced fees for the specialists. Hospitals can be paid according to the same range of options from full charges, per cent discounts, case rates, DRGs to capitation.

The key facet to an HMO is its control of access to the health care providers. Each patient is assigned a primary care gatekeeper. This gatekeeper is responsible for coordinating the care of the individual. This means that the gatekeeper must approve the use of any specialist care or inpatient hospital services. The patient must be sure to obtain a referral before receiving services from a specialist. There are no costs to the patient when receiving care through the approval of his gatekeeper. The HMO pays nothing for care not approved by the gatekeeper.

It is this gatekeeper mechanism that can reduce the patient's access to care. HMO regulations address these access and quality of care concerns. HMOs are subject to provider staffing minimums set by the number of members covered by the plan, rules on the types of services to be provided and times that services must be available. Unlike the usual health insurance plan, HMOs must cover preventive care visits. Another requirement is the operation of a quality assurance program to identify and address any potential undertreatment of the patient.

In addition to the services and provider review, the state insurance departments have oversight over the financial status of the HMO. An HMO is more than just a provider network, it also assumes the financial risk for the health care of its members. Much like an insurance company the HMO establishes and bills premium rates, pays for health care services, and markets to employers. Unlike insurance companies, it usually rates its products differently using a type of rating called community rating. General classes of insured individuals are created and premiums applied irrespective of employers. Insurance companies usually base their premiums on the experience of the actual employer group (experience rating). In another difference with insurance companies, claims are not submitted in the HMO environment. Arrangements for billing are handled directly with the provider. Of course, for those services performed by providers reimbursed on a capitated basis there would be no invoicing of services on a per unit basis. It is this lack of information that has led HMOs to have less developed data bases and reporting capabilities than the more sophisticated insurance companies.

As PPOs have grown in popularity, the HMOs have had to expand their products to include a plan that includes coverage when health care is received not at the direction of the primary care gatekeeper. The constrained nature of the primary care referral system was seen as a major drawback by a number of patients and employers. The ability to exit the HMO system and to have some coverage by the HMO has been attractive to these individuals.

The managed care field is very dynamic. A lot of innovation is underway to find the best financing mechanism or provider network to yield the most cost effective health care. Most experts feel that it is this managed component of the marketplace that will be growing in the future. In California, where managed care is the most advanced, some hospitals already are seeing the majority of their revenues coming from contracts with managed care organizations.

System Advantages and Disadvantages

This brief review should give an impression of the vast array of options available for health coverage in the United States. It is the key strength of this system that it is the marketplace that decides what will be offered. An almost unlimited number of health benefits plans can be designed. This diversity establishes creative opportunities for health delivery and health financing options. Individual choice is critical to the system. This ability to choose creates a unique relationship between the individual patient and provider. Incentives are created for both the provider and the employer to deliver health benefits in accordance with the individual's wishes.

Health financing innovations are moving away from fee for service payment creating a number of interesting and promising options for cost effective delivery. Approaches like DRGs, per case rates, and capitation demand for the providers to deliver health care efficiently and the most cost effectively. Concerns about the drive for lower costs not compromising the quality of health care have led to the development of quality assurance systems by health care providers, government, and insurance companies. Some of these systems are working on the development of clinical outcome measures in an attempt to measure the health status effect of the interaction with the health care system.

Many believe that this health financing structure has been responsible for financing the impressive medical advances of the past decades. These advances have led to an impressive reduction in the length of stay at acute care hospitals. Fewer days at a hospital can reduce instances of hospital obtained medical illnesses.

The disadvantages of the U.S. health financing system are in many ways related to its advantages. All the choice may yield too much choice. For many people the ability to make an informed choice is hampered by their lack of information or understanding. As well, all the options creates a complexity in the administration of health benefits plans which contributes to administrative costs for employers and providers. An employer needs at a minimum an administrator who is well versed in the operation of the health benefits plan- who is covered, what is covered and the administrative procedures necessary to receive payment.

Health care providers have to hire individuals to interact with managed care programs, determine patient portions of the costs, and to work through the maze of paperwork needed to obtain reimbursement from the thousands of health benefits plans.

Increasing costs have also been a problem with the current system. In 1990, health care costs in the United States were about \$2,566 per capita the highest in the world. Twelve per cent of the 1990 gross domestic national product is spent on health care. Health care expenditures are increasing greater than the inflation rate for other services. The costs are straining the budgets of government (both federal and state) and employers.

There is currently a lot of concern in the United States with the increasing number of uninsured. Even those with health insurance coverage are feeling at risk in the health care system, because they do not feel that they can afford the increasing amounts of copayments that they are expected to pay. Consequently, there is a growing public opinion that a reform of the health care system is necessary.

The future of health care financing in the United States is under intense scrutiny. President-elect Bill Clinton has indicated he plans to address the problem of health care cost increases in the first months of his administration. There is much speculation about what will be the end result. However, any change is likely to be incremental and built on the perceived strengths of the current system. Thus, there is only a small chance of creating a national health insurance program. However, it is likely that coverage will be expanded through federal mandates for employers to offer health insurance with certain minimum coverages. Insurance companies may be asked to limit their medical underwriting and preexisting exclusion practices. Small employers may be offered a standard insurance package from pooled plans operated, by either the federal government or contracted fiscal intermediaries. The unemployed will be able to purchase health insurance from these pools using either funds or credits from the federal government. Incentives to use managed care plans and provider networks will be encouraged.