Financing of Health Care in the U.S.

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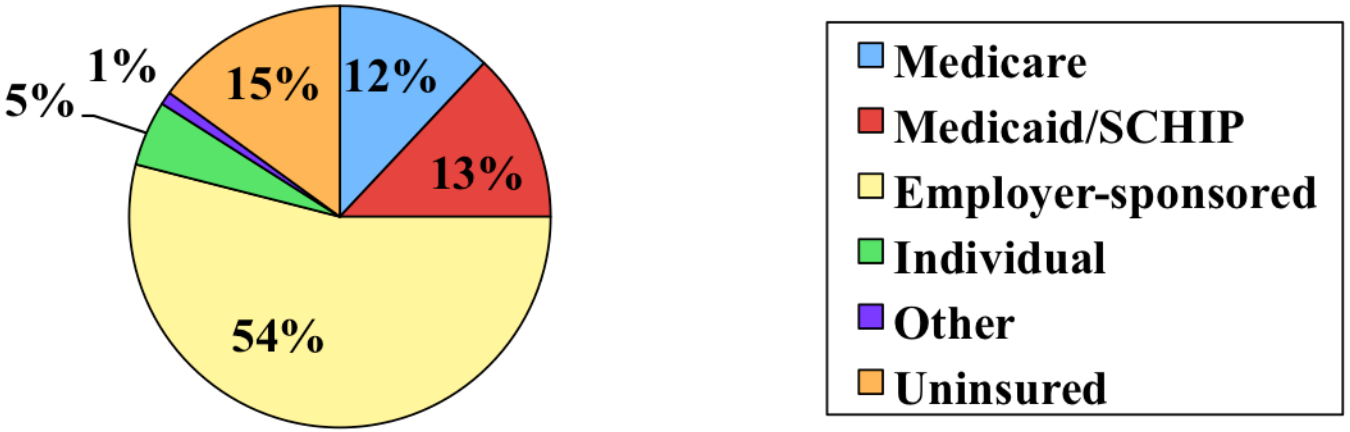
Financing of the U.S. Health Care System: Distribution of Coverage (percent of population)

- In 2008, 20% of non-elderly adults and 10% of kids were uninsured



Medicare

- Beneficiaries are aged >65, permanently disabled with work history, in end-stage renal disease
- There were more than 44 million Medicare beneficiaries in 2006
- Spending totaled $374 Billion in 2006

Medicare Features

- Part A, hospital services is automatic, small premium required for Parts B and D
- Financed mostly by payroll taxes of current workers, premiums on Part B
- Coverage is narrow (though greatly expanded in last decade), with deductibles, coinsurance and coverage ceilings
- Managed care – Medicare plus Choice, now called Medicare Advantage – is an option for many and resembles private coverage

Medicare Payment

- Almost all hospitals and physicians participate in Medicare
- Since 1983, hospitals have been paid a fixed fee per discharge, based on diagnosis, with some adjustments
- Such prospective payment has gradually been introduced in post-acute care, outpatient departments
- Since 1994, physicians have been paid on a fee schedule that was intended to fairly reflect resources

Medicaid

- State/federal program: federal guidelines with considerable state discretion and responsibility
- Federal matching: 50% - 83% depending on income of state residents
- Complex eligibility: income and categorical criteria (originally tied to income support but now independent)
- Low-income families make up the largest group; largest share of payments accounted for by disabled, nursing home residents

Medicaid Benefits and Payment

- Unlike Medicare, Medicaid offers broad coverage including prescription drugs, preventive services
- Limited or no cost sharing for enrollees
- Managed care is pervasive: about 70% of enrollees are covered through these plans
- FFS: Historically low reimbursement -- half or less of what commercial insurers pay
- Physician participation, access to care by enrollees key issues

Private Health Insurance

- Employer-sponsored insurance arose out of wage freeze in WWII accompanied by tax preference for insurance: employers offer coverage for labor market reasons
- Employers can also effectively pool risks, making them a preferable source of insurance than the individual market (more on this later)
- Value-based purchasing efforts have been touted for several decades but employers have been weak stewards of health care quality and cost control

Private Insurance and Provider Payment

- Private insurers typically follow Medicare in method of payment (level is typically higher)
- Variation in payment methods follows insurer and provider market power
- Use of narrow networks (HMOs) and risk sharing has receded since the “managed care backlash” of the late 1990s
- Little innovation in this sector (exceptions tomorrow)

Delivery System

- 60% of hospitals are non-profit; 20% for-profit and 20% publicly-owned
- Public delivery forms part of the safety net for groups without insurance and without means to pay
- Integrated systems of care – across specialties, along the continuum of care – are few: fragmentation of care delivery is pervasive

Key Institutional Issues for Policy in U.S.

- Lack of care systems – small practices without IT, infrequently aligned across specialties and treatment modes (inpatient/ambulatory)
- 47 million uninsured – and related issues
- Mix of federal/state policies interwoven with private insurance markets (regulated state-be-state)
- Market-oriented reforms more likely to be supported

Baseline for Payment Reform

- Provider payment is mostly in silos: the hospital and surgeon are paid separately, all post-acute services are paid for separately
- Medicare implementation of DRGs in the 1980s was broadly successful – reduced LOS without significant adverse effects
- Physician payment reform has been harder: fee schedule changes intended to favor primary care have had the reverse effect over time
- Medicare pilots and private efforts have demonstrated potential value of bundled payments, capitation but risk sharing is controversial with the public, physicians