Module 2 - Access to Health Care and Health Care Reimbursement

Tags	Weekly Modules
Status	Completed

Learning Objectives

Access to Health Care

1. Reasons why the health care market is not a normal market
2. Financial and non-financial barriers to insurance
3. Who are the uninsured and reasons why people are underinsured
4. Regressive and progressive forms of financing
5. Discuss types of health insurance HMO, PPO, POS, HDHP
6. What is COBRA
7. Features of Medicare (A, B, C and D)
8. Discuss access to care issues for woman
9. Discuss models of health care: Medical, Behavioral and Holistic

Health Care Reimbursement

1. Understand Units of payment – Procedure, Day, Episode, Patient, Time
2. Two tiered/three tiered capitation – how does each work?
3. Discuss what carve outs are and how they reduce risk to providers
4. Discuss how reimbursement is trending towards value based purchasing

Access to Health Care

Marian Wright Edelman is an American activist for civil rights and children's rights. This summer we will learn how housing, education, and wages play in important role in one's health.

"The inability to get health care because people lack insurance, kills, less traumatically, and less visibly than terrorism, but the result is the same. And poor housing and poor education and low-wages kills the spirit and the capacity and the quality of life that all of us deserve."
(Marian Wright Edelman Quotes, n.d.)

So, let's start to think about the health care system and the economy.

Health Care is NOT a Normal Economic Market

So why is that? Consider other sectors of the economy first and think about what it means
to say they represent normal economic markets. Take the restaurant industry, for example.
When you go to a restaurant, you sit down and look at a menu. Next to each menu item you
can see the price of that item. If you want a garden salad that costs $8.00 and a turkey sandwich that costs $12.00, you know your total bill will be $20. That is not how health care
works.

Let's see why health care is not a normal market (below from Askin & Moore, 2014, pp. 70-71):

Characteristic	Example
Information asymmetry: Providers, hospitals, and insurers often know things that the patient doesn't know. And providers, hospitals, and insurers all know different things (e.g., pricing, coverage, etc.).	An example of this is the cost of services. When a patient asks a provider the cost of a procedure, the provider does not know. This is determined by the hospital and the insurance company.
Insurance as insulation: Cost sharing by the insurance company hides the real cost from consumers.	As a consumer, you know how much your co-payment is, but you do not actually know what the insurance company is paying. The insurance company negotiates a rate with the hospital or provider. As a consumer of health care, you are not made aware of those insurance negotiations.
Conflicting interests: Physicians may act as the patients' agent and as someone who profits from provided care.	Some hospitals and clinics are for-profit, so the more tests they order, the more money they can make. This can lead to the consumer paying more, especially if they have coinsurance.
Tax subsidies: The health care market is distorted by subsidies provided to employers and employees.	Employers can deduct from their income taxes the money that they contribute towards an employee's health insurance premium. As a consumer, you are not made aware of the financial benefit your employer gets from the government as a result of paying part of your insurance premium.

As you can see from the points above, it's important that an individual is well-equipped within the health care system. Below are some of the benefits of having health insurance.

What are the Benefits of Health Insurance?

The two major benefits of health insurance are increased access to care and better health outcomes:

Increased Access to Care

“People without health insurance are more likely to receive too little medical care and receive it too late, be sicker and die sooner, and receive poorer care when they are in the hospital even for acute situations like a motor vehicle accident” (IOM, 2002, p. 1).

Having health insurance enables people to access care when they need it. If one does not have health insurance, they may not seek the care that they need.

Improves Health Outcomes

People without health insurance more often delay diagnosis, lack access to medications, receive fewer diagnostic studies after a traumatic injury or illness, e.g., a heart attack (IOM, 2002).

You can see that health insurance not only plays a role in accessing care but also may contribute to determining the outcome after diagnosis. As most of us know, early care is better care.

Now, let’s talk about some of the financial barriers to accessing health care.

In the United States, there are many barriers to health care. There are two primary financial barriers.

1. Lack of insurance – if one does not have health insurance, they will be responsible for paying 100% of the cost for obtaining care themselves. In the United States, the Trump administration eliminated the Individual Mandate provision of the ACA which used to require Americans to have health insurance. As of 2018, individuals are no longer required to have health insurance.
2. Underinsurance – this means that you have health insurance, but you do not have adequate coverage. There are four different types of underinsurance
    a. Coverage limits – **you might have a limit on the number of times you can see a practitioner and once this limit is reached your insurance no longer**

pays for your visits. For example, you may be covered for 60 visits to see a physical therapist per year, but you need 65 visits. Your insurance company will not pay for your last 5 visits.

b. Deductibles and co-payments – if your insurance has a deductible then you are responsible for paying this before your insurance company will pay anything towards your health care. If you cannot afford to pay your deductible, then you may not be able to obtain the care you need. The same is true with your co-payment. If you have a $50 co-payment for services and you do not have $50 then you may not go to the doctor.

c. Medicare coverage gaps – Medicare Part B only covers 80% of the final medical bill. If you cannot afford your 20% coinsurance, then you may not seek the care you need.

d. Lack of coverage for long term care - In the United States, if one needs long-term care that means they are no longer able to live at home safely. There are two options to pay for care. First: you can purchase long-term care insurance, which is VERY expensive. Second: you can pay for long-term care out-of-pocket until your net worth is at or below the federal poverty line at which time Medicaid will pay for your care. Once Medicaid pays for your care, they determine which long-term care facility you will reside at. It all depends on which facility has a long-term care bed open for a patient on Medicaid.

These barriers to care have a dramatic affect on individuals if they get sick and do not have insurance to help cover the cost of their medical bills.

Lack of Health Care

So, in the United States, who are the uninsured?

1. Employed and Uninsured - these are individuals **who are working part-time in low-wage jobs.** When **you work part-time, your employer is not required to provide**

you with
health insurance. An example would be someone working two part-time jobs. They might work 20 hours a week at Whole Foods and 20 hours a week at Starbucks. Being
a part-time employee, the employer is not required to offer them health insurance.

2. Unemployed and uninsured - these individuals do not qualify for Medicaid as they may have too many financial assets. An example would be a middle-class worker who
loses their job but owns a home and has some life savings. Their monthly bills continue
to be due (rent, cell phone bill, car payment, etc.) and they do not have enough money
at the end of the month to buy health insurance or pay for health care.

Below is a chart showing the health insurance coverage of non-elderly (0-64) with incomes under 100% of the federal poverty level (FPL) in 2021:

Location	Employer	Non-Group	Medicaid	Other Public	Uninsured	Total
United States [1]	**14.6%**	**6.5%**	**58.5%**	**3.1%**	**17.3%**	**100.0%**
Alabama	14.9%	5.8%	53.2%	4.4%	21.7%	100.0%
Alaska	10.4%	N/A	68.6%	2.0%	16.1%	100.0%
Arizona	14.4%	6.4%	58.3%	2.5%	18.4%	100.0%
Arkansas	11.4%	3.8%	66.5%	3.6%	14.7%	100.0%
California	14.1%	7.4%	63.1%	2.3%	13.1%	100.0%
Colorado	17.4%	9.2%	53.6%	4.3%	15.6%	100.0%
Connecticut	15.5%	6.6%	65.1%	3.4%	9.5%	100.0%
Delaware	16.2%	6.2%	64.3%	3.1%	10.2%	100.0%
District of Columbia	14.9%	5.5%	70.7%	N/A	7.6%	100.0%
Florida	14.4%	11.4%	46.0%	3.6%	24.7%	100.0%
Georgia	14.2%	6.7%	48.4%	4.2%	26.5%	100.0%
Hawaii	20.3%	7.5%	57.9%	6.1%	8.2%	100.0%
Idaho	20.8%	5.6%	55.4%	2.4%	15.9%	100.0%
Illinois	16.3%	5.9%	61.7%	2.5%	13.6%	100.0%
Indiana	17.4%	5.4%	61.7%	2.5%	13.0%	100.0%
Iowa	19.7%	6.3%	59.7%	2.7%	11.6%	100.0%
Kansas	22.1%	6.7%	43.5%	4.2%	23.5%	100.0%

Source: Kaiser Family Foundation, 2023

What you see here is the primary way individuals whose income is below 100% of the FPL obtain their health insurance. For example, in Florida 14.4% receive insurance from their employer, 46% are on Medicaid and 24.7% are uninsured (Florida is a non-Medicaid expanded state).

Faces of Medicaid

The “Faces of Medicaid” video series highlights the range of experience and diverse roles that Medicaid plays in the lives of Americans across the U.S. These stories of individuals on M…

https://www.kff.org/medicaid/video/faces-of-medicaid/

The video shown in the link above is a great example of a family who is on Medicaid. Some of the people who receive Medicaid are students. In this example, the man is finishing his PhD and cannot afford health insurance for himself, his wife, and his daughter. **Due to his low income as a result of being a student, he qualifies for Medicaid.**

Who in the United States lacks health care? There are fourprimary groups.

1. Hispanic people are the largest population enrolled in Medicaid
2. People with incomes less than $25K
3. Part-time workers looking for work
4. People who work for small employers (that have less than 25 employees)

In the United States, why do people lack health insurance?

1. Premiums for employer-sponsored health insurance increased by 160% between 2000-2014. Individuals who are working full time in minimum wage jobs may not be able to afford their premium due to their low-wages.
2. Changing labor force
    a. Increased job layoffs and lack of insurance. When an individual loses their job, they can stay on their employer's health insurance plan for up to 18 months, but they must pay the entire premium themselves. Most cannot afford to do this as they no longer have an income.
    b. Slower economy causing many employers to decrease health benefits or shift an increased percentage of the premium cost to employees. Employers can decide what type of health insurance plan they will offer their employees. To save money, some are starting to choose high deductible plans as the premiums are the least expensive so they spend less money.

c. Shift from full-time unionized workers to part-time low-wage non-unionized and clerical workers. Some employers are laying off full-time employees and hiring part-time employees to replace them. This way the employer saves money by not having to offer the employee health insurance as they only work part-time.

Differences in Health Insurance

Health insurance deductibles have risen substantially over the past 11 years as you will see
below. This means that individuals must pay more out-of-pocket before their insurance company will pay anything towards their health care.

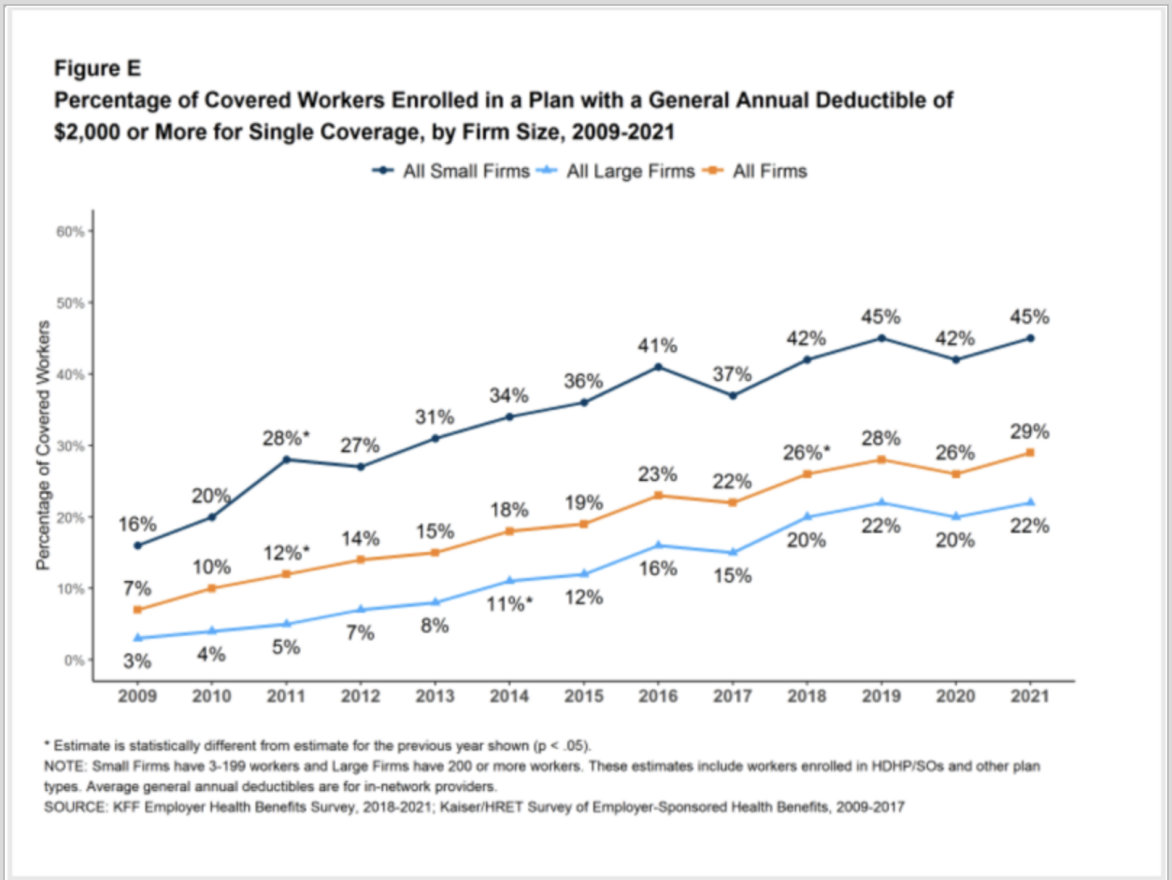
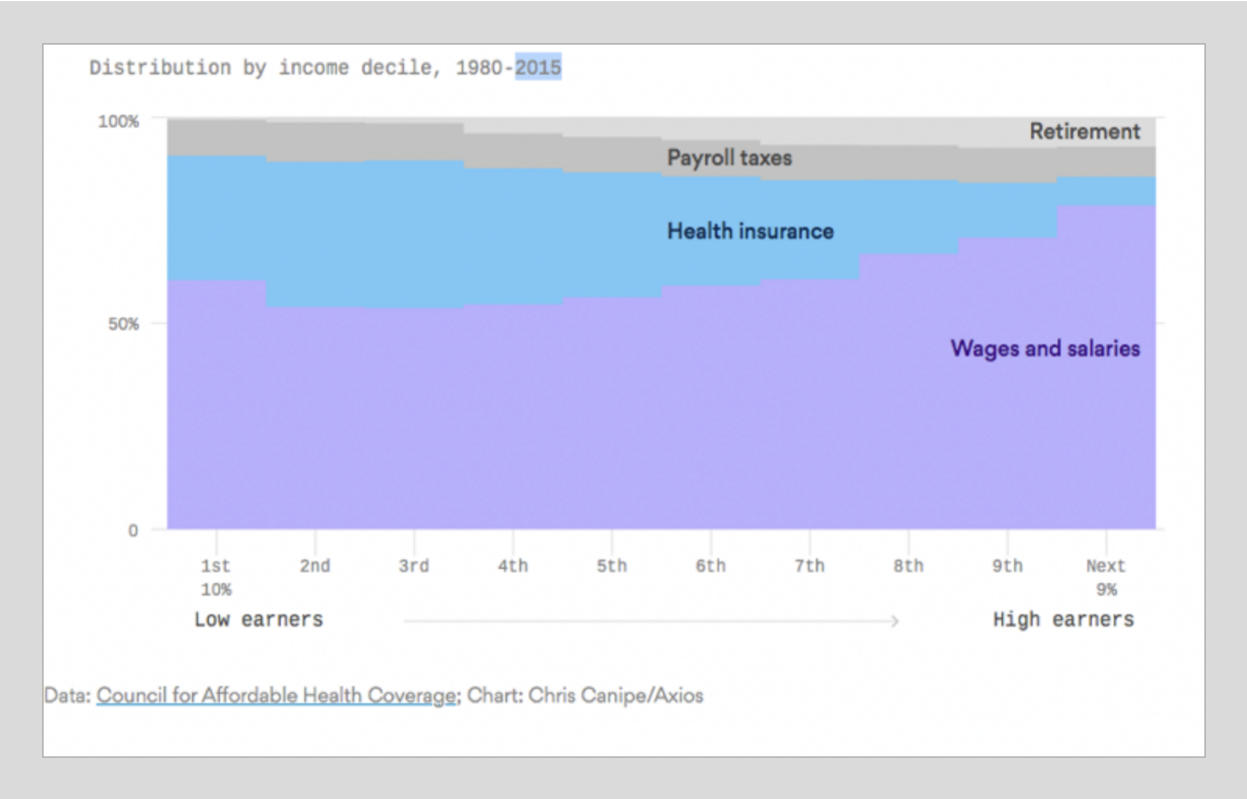


Figure E: Percentage of Covered Workers Enrolled in a Plan With a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2021

Retrieved from: https://www.kff.org/report-section/ehbs-2021-summary-of-findings/

As you can see from this graph whether you worked for a small firm or a large firm, you saw
an increase in your health insurance deductible almost every single year. Small firms saw
the greatest rise. Every year employers are faced with rising premiums. To avoid paying higher premiums, employers can choose to offer a health insurance plan to its employees
that has a higher deductible, which is paid for by the employee.

Lower premium = higher deductible.



What you will see in the graph above is that low-wage earners in the United States pay a greater percentage of their wages towards their health insurance as compared to higher wage earners. For example, Jeff Bezos, when he was the CEO of Amazon, paid the same premium for his health insurance as one of Amazon's full-time warehouse workers. The cost affects a warehouse worker more significantly as their wage earnings are much lower than Jeff Bezos.

Source of Health Insurance in the United States

Health insurance deductibles have risen substantially over the past 11 years as you will see below. This means that individuals must pay more out-of-pocket before their insurance company will pay anything towards their health care.

	Number of People (millions)	Population (%)
Medicare[a]	55	17
Medicaid	62	19
Employment-based private insurance	152	46
Individual private insurance	29	9
Uninsured	28	9
Total US population	326	100%

(Bodenheimer et al., 2020, p.20)

What you see in this graph is that **the majority of people in the United States obtain their health insurance from their employer.**

In the United States, there are 3 primary ways in which individuals are covered by health insurance plans:

1. Indemnity Plans - These are not common today. They were more common in the 1970s and 1980s. **Indemnity plans typically do not have cost sharing (co-payments or coinsurance).**
2. Managed Care Organizations
    a. Health Maintenance Organizations

    b. Preferred Provider Organizations
    c. Point of Service Plans
3. Consumer-Driven Health Plans
    a. Health Savings Accounts
    b. Flexible Spending Accounts
    c. Health Reimbursement Accounts

Let's look at some of these in more detail:

Health Maintenance Organization (HMO)

- Most tightly integrated plan
- Must have a Primary Care Physician (PCP), who is responsible for your health care, making referrals to specialists and approving any medical treatment
- Must pay a co-payment for services
- Care received from caregivers outside the network is NOT covered

So, what are some of the pros and cons of an HMO? First, the premiums are lower and there is a true emphasis on prevention. On the other hand, individuals with an HMO have a limited selection of providers they can see and their ability to obtain specialty care might be difficult. For example, in Boston, if you want to see a specialist at Massachusetts General Hospital and that provider is not part of your HMO network, then you cannot see that provider unless you want to pay the full cost of the visit yourself.

Preferred Provider Organization (PPO)

- **Typically, is the most expensive premium**

- Has a provider network and non-network providers
- **Enrollees can self-refer to any provider at any time**
- You CAN have a Primary Care Physician (PCP), but you are not required to
- Who might want this plan?
    - Individuals who want to be free to choose their provider.
    - Individuals can see both in- and out-of-network providers, allowing them the most freedom of choice.
    - **With a PPO you do not need to obtain a referral to see a specialist.**

Consumer-Driven Health Plans

These are associated with health plans which have high deductibles (High Deductible Health Plans – HDHP). Many times students will ask: Who would choose a health plan with a high deductible? When individuals obtain their health insurance from their employer, they may not have another option besides a high deductible health plan.

- Tax free bank accounts used only for medical expenses.
    - These are set up through your employer and can include Health Savings Accounts (HSA), Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA)
    - These accounts allow for individuals to use pre-tax money to cover their deductibles, co-payments and coinsurance
    - A Health Savings Account is set up ONLY for individuals who have high deductible health plans. The amount they can contribute to an HSA is higher than a FSA or HRA as their deductible is much higher and this savings account is designed to allow then to be able to pay for their deductible. Flexible spending accounts and health reimbursement accounts are for any individuals, regardless of the health insurance plan type they have. This money, which is put away into their account was taken out pre-tax allowing them some savings on their out-of-pocket medical expenses.

Now let’s look at what type of health insurance plans people were enrolled in 2021. As you can see most are covered by high deductible health plans and HMO’s.

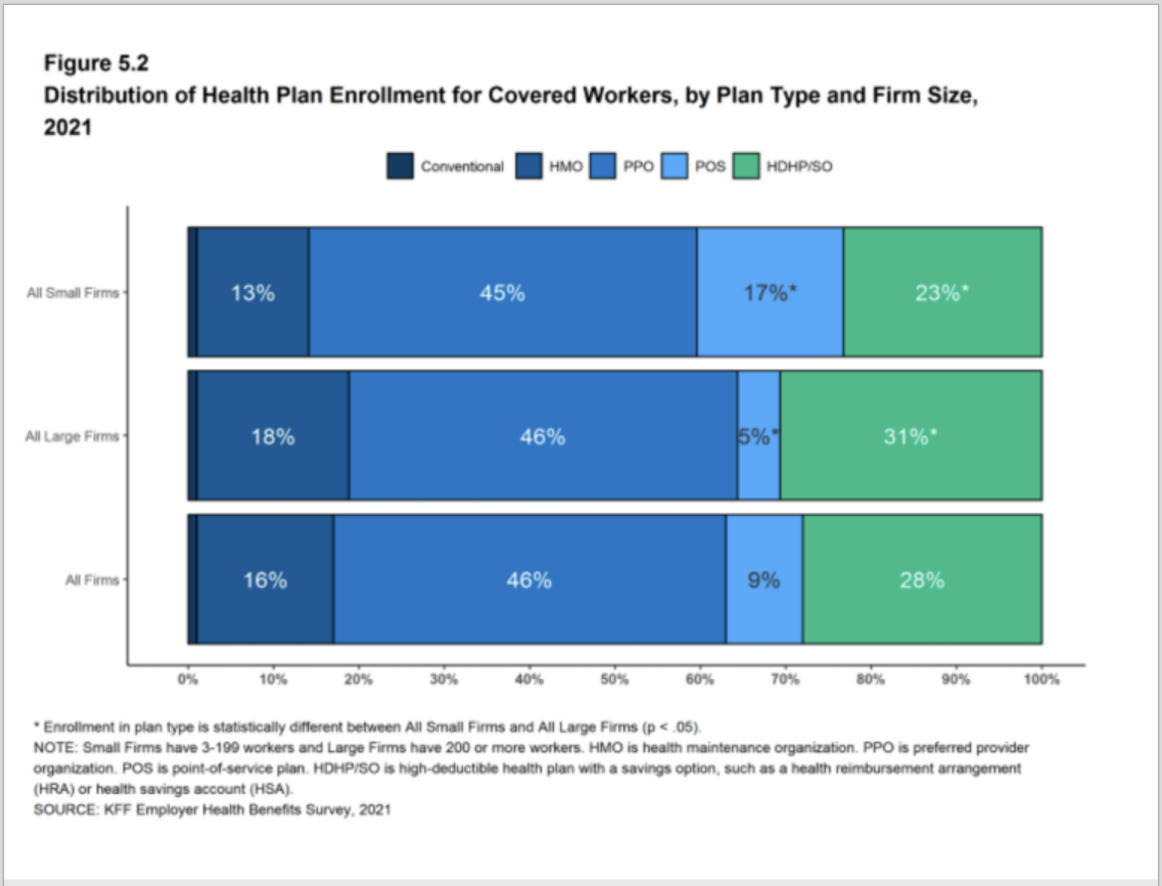


Figure 5.2: Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2021

KFF, 2021. Retrieved from https://www.kff.org/report-section/ehbs-2021-section-5-market-shares-of-health-plans/

Question: Why do you think the greatest rise is in high deductible health plans?

Answer: Because they offer the lowest premiums for employers which saves the employer money.

Access to Care

Now we need to think about how to increase access to care. There are three primary ways access to care can be increased.

The first is through the Consolidated Omnibus Reconciliation Act (COBRA) of 1985. When people lose their insurance as a result of divorce, job loss or death of a family member, the individual may stay on their employer-sponsored health insurance plan for up to 18 months, but they have to pay the entire premium themselves. The employer is no longer required to share in the cost of the premium.

The second is Medicare. Medicare increases access to health care for individuals who are over 65, have chronic renal disease, are disabled, or have ALS. Medicare A allows access to hospital care and Medicare B allows access to outpatient services. Please remember that enrollees in Medicare must pay deductibles, co-payments and coinsurance which can be challenging for some.

The last is Medicaid. Medicaid provides health insurance for individuals in the United States who earn less than 138% of the federal poverty line. Please remember that not all providers accept Medicaid due to the low reimbursement rate. Individuals who are on Medicaid as compared to those who are uninsured are more likely to have a regular source of medical care and utilize more preventative services. They also report fewer delays in receiving care.

So why do people who have Medicaid have trouble getting a doctor?

Medicaid to Medicare Fee Index

Location	All Services	Primary Care	Primary Care for Physicians Eligible for Increased Fee	Obstetric Care	Other
United States	**0.72**	**0.66**		**0.81**	
Alabama	0.75	0.65	1.00	0.88	
Alaska	1.26	1.27		1.25	
Arizona	0.80	0.73		0.92	
Arkansas	0.80	0.65		0.70	
California	0.52	0.41		0.60	
Colorado	0.80	0.84	0.84	0.67	
Connecticut	0.76	0.76		0.81	
Delaware	0.96	0.99		0.84	
District of Columbia	0.79	0.80		0.79	
Florida	0.56	0.48	0.53	0.82	
Georgia	0.77	0.65	0.89	0.85	
Hawaii	0.62	0.54		0.64	
Idaho	0.95	1.00	1.00	0.89	
Illinois	0.61	0.48		0.85	
Indiana	0.77	0.75	0.75	1.00	

(Kaiser Family Foundation, 2022)

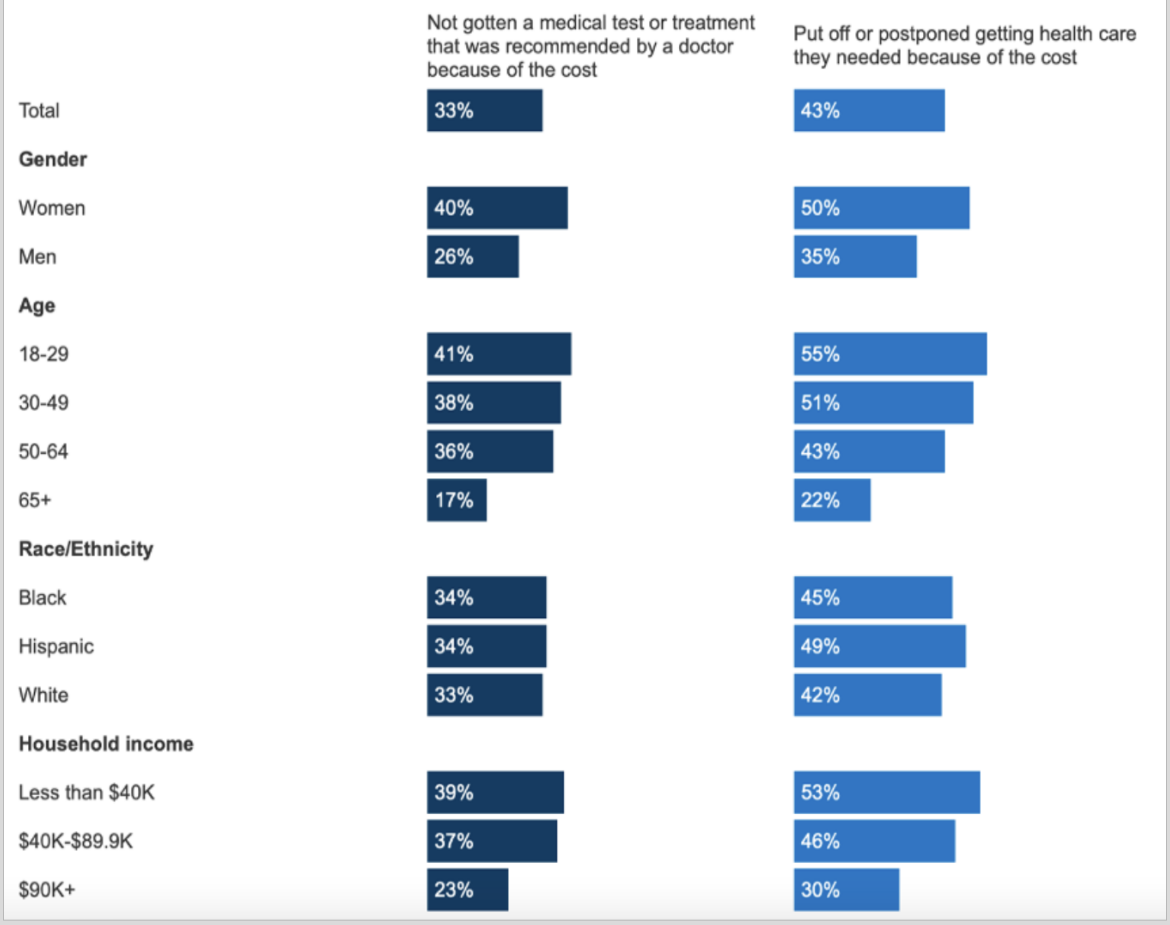
What you see here is a comparison of Medicaid reimbursement vs. Medicare reimbursement. For example, in Florida, Primary Care Physicians are reimbursed by Medicaid only 48% of what they would be reimbursed for providing services to a patient on Medicare. So, a physician would be reimbursed 52% less for a Medicaid patient than for a Medicare patient.

The rising cost of health care has caused individuals in the United States to delay getting treatment for conditions they suffer, even serious conditions, as you can see on the graph below. Please remember that early care is better care. But due to rising costs this is not always possible.

Figure 2

One-Third Of Adults Say They Or A Family Member Have Skipped Recommended Medical Treatment Due To Cost, While Four In Ten Say They Have Delayed Needed Care

Percent who say, in the past 12 months, they or another family member living in their household has...



Retrieved from https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

Now we will discuss the non-financial barriers to health care.

There is a Primary Care Physician shortage in the United States. How do you explain this?

First: PCPs receive the lowest salary of all medical doctors yet their cost to attend medical school is the same as those entering a specialty field, e.g., neurosurgery or anesthesiology.

Second: The patients living in rural areas need to travel to reach the nearest health care facility. For some who live in rural areas in the United States the closest medical facility might be 300+ miles away.

Third: The need for language and cultural compatibility between a provider and a patient. If a provider is not fluent in the language of the patient or culturally compatible with the patient, it will be difficult to provide care.

What challenges do you think woman face with regards to access to care?

Women are more likely to be dissatisfied with physician care, and receive lower quality preventative care. They are less likely to fill a prescription than men and they are more likely to be on Medicaid, making it difficult to find a physician.

Minority women have a higher incidence of new HIV/AIDS cases. Why do you think this is the case?

They have no primary care doctor, and may not schedule appointments with doctors due to cost. They may be less educated and more likely to be living in poverty.

Is our health system using a model that encompasses all health determinants?

Before we can answer this question, we need to think about the three different models used in the United States.

First is the Medical Model – This model assumes the existence of illness or disease. It emphasizes clinical diagnosis and medical interventions to treat the disease and its symptoms. An example would be going to see a doctor because you have a sore throat. The doctor looks in your throat, sees that it is red and has white patches and orders a rapid strep test. If the test comes back positive, they prescribe you an antibiotic and send you on your way. They do not ask any questions about you as a person; they only focus on your symptoms.

Second is the Behavioral Model – This model assumes that the illness or disease process results from an interaction between the individual and the environment. Using the example above, the same patient presents with a sore throat but, following the Behavioral Model, the doctor might ask about the patient's living situation (environment). The patient might report frequently sharing drinks with their roommate, which could have been the cause of the strep infection. **In this model, the doctor would not only prescribe antibiotics but also educate the patient on not sharing drinks with their roommate.**

Last is the Holistic Model – This model **emphasizes all aspects of a person's life and adds a spiritual dimension.** Using the Holistic model, the doctor would consider the patient's physical state, mental state, social state, and their spirituality. This model truly encompasses all aspects of the patient.

So now I want you to think about which model you would want to be applied to you. The medical, behavioral, or holistic model?

In summary, there are two major barriers to accessing health care: financial and non-financial. Remember that access to health care does NOT ensure health but it is a necessary beginning.

Reimbursing Health Care Providers

Now we are going to learn about **health care reimbursement.**

One of the key ways to understand reimbursement is to establish the UNIT of payment. There are 5 payment units that we will be discussing.

Where did these units of payment come from? As you remember, back in the late nineteenth/early twentieth century, physicians and patients bartered for their care. Then physicians wanted to be paid for their services and this is when insurance companies developed. Remember Blue Cross/Blue Shield was one of the first. Today, there are many insurance providers and hundreds of different plans that consumers can choose from.

Managed care plans developed new methods of reimbursement to help contain cost.

Risk in health care refers to the potential to:

- Lose money
- Earn less money
- Spend more patient care time without additional payment

“As the definition of risk is “the potential to lose money, earn less money, spend more time without additional payment on a reimbursement transaction” (Bodenheimer et. Al., 2020, p.38).”

Think for a moment – what does it mean to aggregate?

- Aggregate means to bundle.

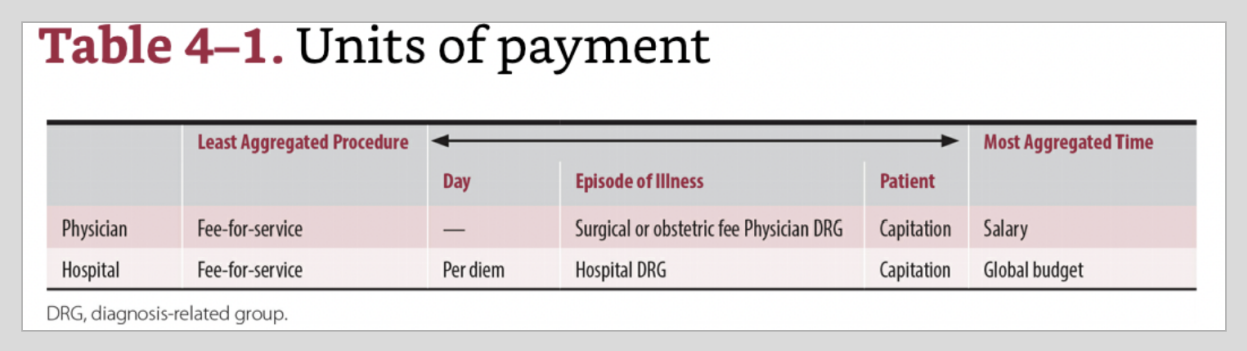


Table 4–1. Units of payment

	Least Aggregated Procedure	←			Most Aggregated Time
		Day	Episode of Illness	Patient	
Physician	Fee-for-service	—	Surgical or obstetric fee Physician DRG	Capitation	Salary
Hospital	Fee-for-service	Per diem	Hospital DRG	Capitation	Global budget

DRG, diagnosis-related group.

As you can see, **the least aggregated form of payment is fee-for-service.** What this means is that when an individual sees a doctor the doctor codes for all the procedures they perform during that visit. For example, if you go to see a doctor for low back pain and a sore throat the doctor will code for evaluating your low back pain and will also code for testing you for strep throat. The insurance company will reimburse for all the codes that the doctor enters.

After fee-for-service you have per diem. **Per diem means per day.** This form of reimbursement is not common anymore. Being reimbursed a per diem rate means that for every day a patient is in a hospital the insurance company pays the hospital a per day rate regardless of how much skill or time it took to care for that patient.

The next form of payment, as we move along the aggregation line, is **episode of illness. Episode of illness is based on a DRG. DRG stands for diagnostic related group.** When an individual enters the hospital for a total knee replacement, for example, the patient receives a DRG code. The hospital is **reimbursed a set amount of money that has to cover all of the patient's care for the total knee replacement.** This reimbursement covers the cost of the surgeon, the nurses to take care of the patient, the medications administered to the patient, and the hospital stay the patient requires due to the surgery. This is why a patient's stay in the hospital is limited. For a total knee replacement that is not complicated, an average patient spends 23 hours in the hospital. **If the patient stays longer than 23 hours the hospital is at risk for losing money as they will not get reimbursed more.** Another example would be childbirth. If you have an uncomplicated delivery the expected length of stay in the

hospital is 36 hours. This is based on the DRG for a vaginal delivery of a baby. If you stay longer in the hospital, the hospital will not get reimbursed more.

Moving closer to the most aggregated form of payment, we have capitation. **Capitation is one payment per patient over a period of time.** This is a **very common method of reimbursement with primary care physicians.** For example, a physician will receive a capitated payment for each patient they treat. This payment must cover the patient's care whether they come in 4 times a month, once a month or never.

Finally, **the most aggregated form of payment is a salary or a global budget.** For example, physicians that work for a hospital receive an annual salary. Regardless of how many or how few patients they see annually they receive their salary. A global budget is a mode of reimbursement for the military and Medicare/Medicaid. At the beginning of the fiscal year, the provider is given a fixed amount of money to cover all medical services for the year. This amount has to cover all services rendered that year.

Below you can see this broken down into bullets (from Bodenheimer et. al., 2020, p. 36):

- Fee-for-service
  - Procedure and visits
  - Based on individual components of health care
- Per Diem (Hospitals)
  - Day fee for specified services delivered
- Episode of Illness
  - One sum for all services delivered
- Capitation (Physicians/providers)
  - One payment per patient per period of time
- Payment for all Services
  - Global Budgets, Salaries

Let’s break down the payment types a little more:

Physician Payment		
Payment		Focus/Payment unit
Fee-for-service	-->	Procedure
Episode of Illness	-->	Bundled Fees
Capitation	-->	Patient
Salary	-->	Time

Fee-for-service (FFS)

Prior to the 1980s, **the amount paid for a medical service was based on what providers in the area usually charge for a medical service.** This is also known as **Usual, Customary, Reasonable (UCR).** The problem with this was that practitioners could bill for multiple different procedures in one visit and the insurance company would pay the total amount that was billed. This put the insurance company at risk of potentially paying for procedures or exams that may not have been necessary.

In the 1990s and 2000s – Medicare developed **a resource-based relative value scale**. This scale estimated the amount of time, mental effort, judgment, technical skill,

physical effort, and stress that it took to perform examinations, procedures, and treatments. The insurance company was now **in a position of power as they determined what they would reimburse physicians.** This was the start of a fee-for-service reimbursement schedule. Once this was adopted by Medicare, private insurance companies followed suit.

▼ **Explain in more details:**

Fee-for-Service (FFS) is a model of health care payment where **services are unbundled and paid for separately.** In healthcare, **it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care**, rather than the quality of care. The provider is paid a separate fee for each service such as lab tests, hospital stays, and office visits.

Before FFS, the Usual, Customary, Reasonable (UCR) payment model was common, which was based on usual charges by providers in a specific geographical area for a given service. However, this model didn't have any checks or balances in place to prevent overbilling or unnecessary procedures, putting insurance companies at risk.

This system evolved in the 1990s and 2000s with the introduction of **Medicare's resource-based relative value scale (RBRVS).** The RBRVS model shifted the focus from billing based on local rates to billing based on the estimated resources used in providing a service. These resources could include time, mental effort, judgment, technical skill, physical effort, and stress involved in delivering a medical service.

This shift gave insurance companies more power and control over the reimbursement process, as they could now determine what they were willing to reimburse for each procedure or treatment, rather than simply accepting the billed amount. The adoption of this model by Medicare influenced other private insurance companies to adopt similar FFS models.

In the FFS model, the more services a physician provides, the more they get paid, which can sometimes lead to an overuse of medical services. This is one of the reasons why alternative payment models like bundled payments, capitation, and pay-for-performance have emerged to try to balance the need for care with the costs of services. These models aim to **encourage quality over quantity in healthcare.**

Episode of Illness

With episode of illness, **specialists receive one bundled payment for the case or episode.** An example is obstetrics or surgery. The surgeon or obstetrician would receive a set fee for the delivery of a baby or for performing a surgery.

Now let's think about physician risk. As you learned earlier, capitation is a set amount of money to cover a person's medical care for a specified amount of time (typically per member per month). But what if a patient is older and has a lot of co-morbidities and the physician has to spend more time with that patient? They could be at risk of losing money.

To adjust for this risk, insurance companies created carve-outs. Carve-outs adjust for financial risk. They are paid separately (limited reintroduction of fee-for-service) from the capitated payment.

Carve-outs cover immunizations, office tests, minor surgical procedures. Basically, insurance companies did not want physicians to limit tests, immunizations, or minor surgical procedures due to the fact they were not paid more for these services.

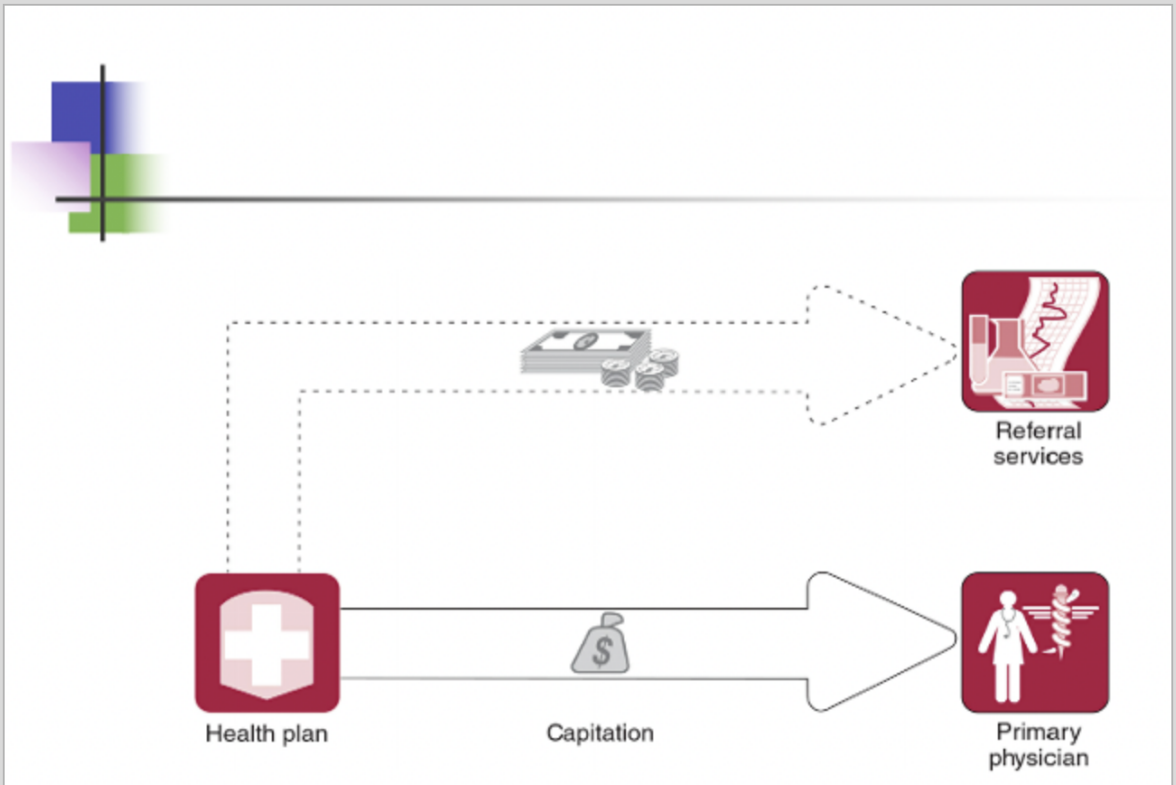
They also instituted **risk-adjusted capitation. This is reserved for providers who treat higher risk patients such as those who are elderly or have chronic diseases.**

So what are some of the merits of capitation?

1. Nurses/assistants can provide “virtual” visits.
2. Improved care delivery – each patient has a primary care physician
3. Can provide care without uncertainty about how much or whether a service will be paid for

(Bodenheimer et. al., 2020, p. 38)

Let's take a look at some capitation payment models. Below is the **two-tiered model**:

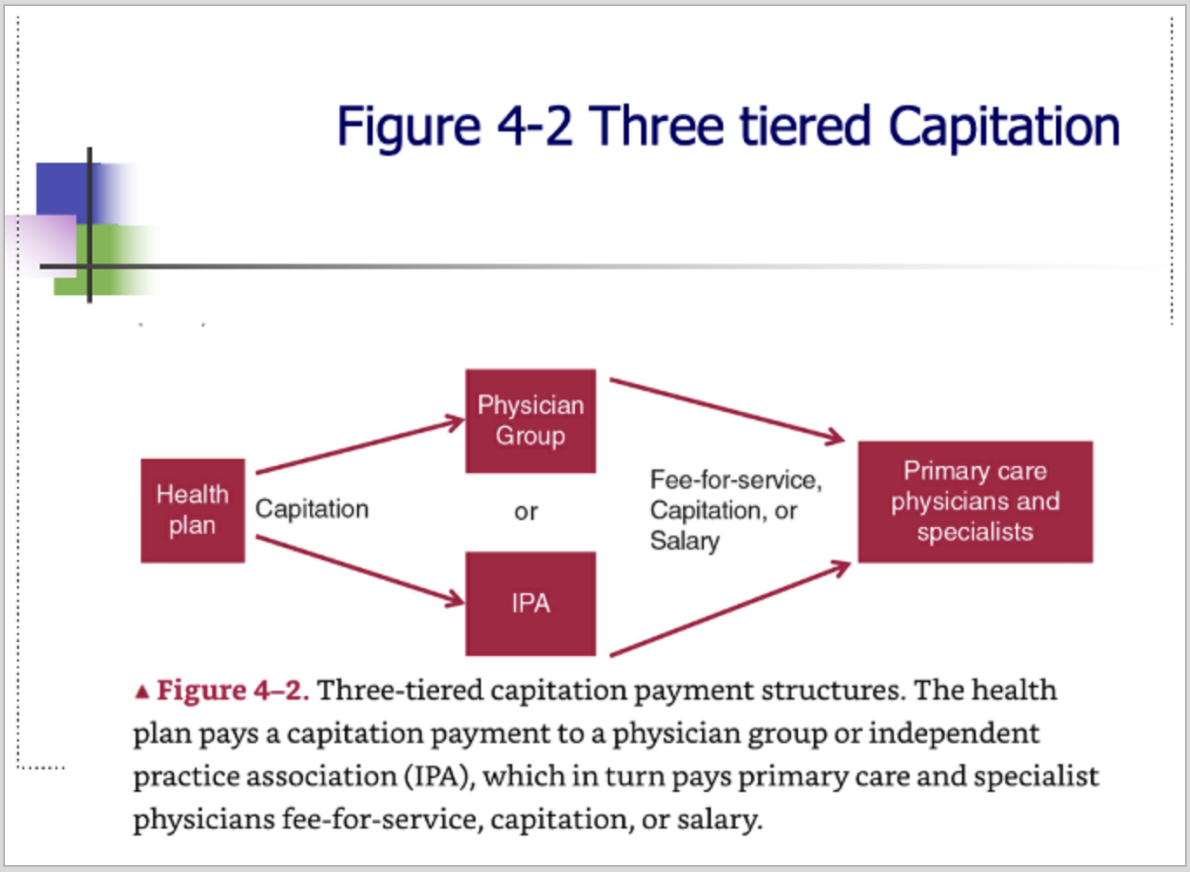


▲ **Figure 4–1.** Two-tiered capitated payment structures. The health plan pays the primary care physician by capitation and pays for referral services (e.g., x-rays and specialist consultations) through a different payment stream.

(Bodenheimer et. al, 2020)

As you can see, in two-tiered capitation, the insurance company pays your primary care physician a capitated rate (per member per month) but if your PCP needs to refer you to a specialist then the insurance company will pay the specialist you see.

Then we have **three-tiered capitation**:



(Bodenheimer et. al, 2020)

In a three-tiered capitation model, the health plan pays a capitated rate to either a physician group or an IPA (Independent Practice Association). The Physician group or IPA pays either a capitated rate, fee-for-service or salary to Primary Care Physicians and specialists.

Salary

This is payment for time.

In the public sector, medical professionals in the Veterans Administration, the military, and those working for the state or federal government receive an annual salary.

In the private sector some surgeons in hospitals are paid an annual salary as are those who work directly for an HMO.

Reimbursing Hospitals

Hospital Payments

Now we are going to look at hospital payments:

Hospital Payment		
Payment		Focus/Payment unit
Fee-for-service	-->	Procedure
Per Diem	-->	Day
Episode	-->	Bundled Rate
Capitation	-->	Patient
Global Budget	-->	Time

Fee-for-service – Hospital

Fee-for-service rates used to be based on “reasonable costs.” In this era of cost containment, insurers are questioning “reasonable cost” and they are negotiating lower payments. Insurance companies are steering away from fee-for-service and shifting to per diem, episode of illness, or capitated payments.

Per Diem – Hospital

This is a daily rate where all services are bundled together. This is the opposite of fee-for-service, as **all costs are bundled into one payment.** This is not a common form of reimbursement now.

Episode of Illness - Hospital

Episode of illness is **based on Diagnosis Related Groups (DRGs).**

These were established by Medicare in 1983.

A lump sum is paid based on the diagnosis. Each diagnosis is associated with a DRG. Say for example you need a total knee replacement. The procedure is reimbursed based on the negotiated fee for the total knee replacement DRG. This fee must cover all associated costs, e.g., anesthesiology, nursing, overnight stay, etc.

Per Patient – Hospital

Capitated payment – this does not occur anymore.

Global Budget – Hospital

This is a fixed payment for all services for one year. This form of payment is common in VA hospitals and in the defense department. They get a fixed amount of money every year and that payment has to cover all services rendered for an entire year.

What the Heck is Value-Based Purchasing (VBP)?

Wondering about Value-Based Purchasing? Well you've come to the right place. Sit back and enjoy this high-level overview of the concept told by a colorful cast of characters and voiced by some of

https://youtu.be/dF8SGblP7-c

From the video above, you can see that quality of care is now what is valued when thinking about reimbursement.

In conclusion:

Cost containment in the 1990s focused on limiting the number and cost of services that were being bundled into one payment, thus shifting the risk from insurers to providers. Traditional fee-for-service was then replaced by fee schedules.

Now we are in an era of blended payments with negotiation between payers and providers and the use of fee schedules for fee-for-service. (Bodenheimer et al., 2020, p. 43)