

Financing Health Services: Healthcare Insurance, Payment Method

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for
CDR Toni Whitmeyer

“Propose and debate the pros and cons of three alternative methods for financing healthcare in the US. Which of your proposals do you consider the most likely to be adopted and why? What policy and/or regulatory changes would need to be effected to implement your proposed alternative? How would this proposal affect the financing of government healthcare programs for the military, veterans, federal employees, elderly and economically disadvantaged?”



Brian P. Mulhall
Jeff Tjaden
Kari Stone
Rena Nicholas
Kirk Winger
Michael Nack



United States history is marked by myriad technological, economic, and sociological achievements, from landing a man on the moon, to a trillion dollar GDP, to unparalleled societal freedom. However, there are some strange contradictions in U.S. history that are not lost on historians or contemporaries, including the paradox of extraordinary expenditures, major technological advancements and the conquering of major disease entities juxtaposed to sub-standard infant mortality rates, a relative inattention to public health measures, and the failure of the U.S. Health Care System (HCS) to provide universal coverage for all of its people. The failings of our current HCS are proving a major impediment to continued economic and social progress and are staining the psyche of the American people.

Many efforts have been made over the past several decades to address the problems in our HCS. Scientific advancements continue to provide the US with unparalleled success in disease recognition and intervention, with the resultant prolongation of life to ages not heretofore seen. Unfortunately, the enormous cost of these successes and the uneven access for all members of U.S. society has made cost-containment and improved access two of the major identified problems requiring solutions. The best method(s) for financing this increasingly expensive system have been vigorously debated. The U.S. has looked for solutions in the models defined by other healthcare systems, like Canada, Great Britain and Germany. Nevertheless, the complexities of our HCS and American society have made wholesale adoption of another system unlikely. Several methods of financing healthcare have been isolated as possible solutions, but none appear to be superior. Therefore, in this paper we will discuss the present methods for financing healthcare and several proposed alternatives (usually as a sub-text to current methods). Presently, the three major modes of healthcare finance include: private pay, health insurance, and federal-sponsorship of programs. Given previous debates, alternative methods of healthcare financing will likely incorporate variations upon many of these themes.

Health Insurance

Health Insurance (HI) serves to pool money and distribute risk across a larger population, as illness can be unpredictable and financially catastrophic for an individual or family without large reserves. Further, pooling funds can allow for greater leverage in negotiating access costs and avoiding the individual expense of indebtedness (for these often unanticipated expenses). Between 70-80% of the U.S. population have some form of HI, and this system currently provides more than 1/3 of all health care dollars. Most of the HI for those under 65 is employer-funded, while government-sponsored insurance is the norm for those over 65 (with some HI supplements). The three broad categories of insurance in the U.S. are generally related to employment status: **1)** Voluntary Health Insurance (VHI) or pre-paid coverage (Blue Cross/Blue Shield(BC/BS), HMOs) for the employed via employer-sponsored programs (monies come from the employer > employee); **2)** Social Health Insurance (SHI) or Medicare for the aged and disabled (with monies coming from employment-based tax contributions); and **3)** Public Welfare/Assistance or Medicaid for the poor and unemployed (with monies coming from the government and services provided essentially as charity).

Private insurance companies are less able to impact cost of healthcare by influencing consumer choices, negotiating with providers and pharmaceutical companies for the best

deals, and promoting health-oriented behavior (which could reduce long-term costs) when compared to pre-paid systems. BC/BS and HMOs provide broad benefits and strive to control costs by narrowing choices, negotiating for the lowest costs, and limiting certain services or access (to sub-specialists, for example). Individuals or employers pay a monthly premium and individuals may have deductibles or co-pays for many services. (source: Checkup on Health Insurance Choices. AHCPR Publication No. 93-0018, December 1992. Agency for Health Care Policy and Research, Rockville, MD)

There are many pros and cons to employer-based insurance. First and foremost is the need to be employed. If one is unemployed, episodically employed, transitioning between employers, or working for an employer that does not provide such benefits, that person is one of the many 'uncovered' members of this society. Another frequently-mentioned problem with individual or employer-based healthcare insurance is the concept of moral hazard. Moral hazard is the proclivity of people to use what they feel they have a right to use. In the case of healthcare, individuals may be less discrete or cautious regarding their choices since they do not directly bear the consequences (cost). Therefore, an insurance-oriented system may ultimately increase costs because neither the consumer nor the provider has an incentive to limit the use of resources.

One of the clearest problems with our current HI system or its possible expansion (to cover the uncovered) is the all-too-apparent desire of employers to reduce their contributions to this 'employee benefit.' Increasing competition, increasing healthcare costs (premiums for insurance rose about 12.7% this year according to the Kaiser Family Foundation survey), and increasing expectations from stockholders are all arguments made by corporate America to rationalize their withdrawal from financing the HCS. This 'employee benefit,' now perceived as a 'right of employment,' is likely to dwindle or disappear without substantial intervention by the government.

Alternatives to HI posed by corporate entities are the medical savings account system (DPCs) or the voucher system. This would fix (stabilize) or eliminate the contributions made by employers and would return responsibility (and liability) for healthcare decisions to the employee. Some argue this system would decrease the "moral hazard" and curb further inflation of medical costs. (Journal of Healthcare Management, 2000). Unfortunately, the DCP, Medical Savings Account or voucher system has a limited track record, may increase costs due to administration of these systems, may eliminate the leverage afforded to large purchasers of HI, and may not transfer with the employee after job-loss or retirement. Further, there is likely to be a learning curve for employees newly resuming the role of responsible consumer, and the short-term consequences of this delay could be expensive. With these systems, there is no incentive for the employer to educate, protect, or advocate for the employee in the new healthcare environment.

Social Health Insurance

Social Health Insurance (SHI) is a popular method of financing, seen in various formats in many countries (i.e., China, Thailand, Bangladesh, Russia, Romania, Hungary, Germany, and many others). SHI is a centralized fund or insurance system that relies on variable contributions from taxes and employers to provide healthcare coverage to all members of a society. SHI has been demonstrated to provide a stable revenue source that can be distributed to the HCS. In different countries, it has been established and run by the government, but it can also be independent from the government and run by the

private sector. SHI is not a National Healthcare System, and cannot directly control the HCS or alter the provision or distribution of services in a country because providers are generally independent contractors that operate according to established market rules.

In Germany, for example, over 90% of the population is covered by SHI, with the remaining 10% covered through private or other types of insurance (less than 0.5% do not have insurance). Expanded coverage started regionally and then grew to include more occupations. Those individuals not falling under these plans were gradually covered by municipality insurance (sickness funds). Children and spouses are generally covered under the worker's plan with individual contributions independent of family size. This process enabled an incremental expansion of coverage.

The German SHI is made up of a number of separate sickness funds and members get to select the fund they join. Contributions are based on the level of pay (a percentage of paycheck deducted monthly), funds are non-profit and each is required by law to balance profits/losses by the contribution rate, making the expenditures dependent on the morbidity of the members. The worker's contributions are the only source of revenue, and have varied from 7.8-16.8%. The German system remains independent of market and state governance, so the non-profit organizations are expected to self-govern. (However, given this design, implementation in a country with a high rate of unemployment or informal work sectors would place a high burden on the implementation of this health plan.)

In contrast, only half of the expenditures in U.S. HCS (46%) are financed by state and federal governments (i.e., Medicare and Medicaid). These funds do come from taxes (personal income tax, corporate income tax and various excise taxes) and are distributed evenly across the eligible population, regardless of their lifetime contributions. Medicare is composed of two parts: Part A covers hospital costs, home health visits and SNFs and is available to all eligible persons; Part B provides payments to providers, for medical supplies, outpatient services, rural health clinic visits and home health visits for those without Part A. Part B has a deductible and a premium of \$50/month.

Medicaid is a federally-mandated, state-run welfare program to serve the medical needs of the poor. Medicaid derives funds from both federal and state taxes. Though it has strict eligibility requirements and well-defined services under coverage, it has become the fastest growing segment of HCS financing. Medicaid has become the largest payer of long-term care services and financed 47% of nursing home care in 1999 (Williams & Torrens, 2002). In 1967, the two programs (Medicare and Medicaid) represented only 15% of the total health care bill, yet in 1999, they compromised 34%. As cost-saving measures, the US Government has implemented several new programs or approaches: Prospective Payment system (PPS) using weighted DRGs; Physician reimbursement using RVUs, and Selective Contracting using PPOs. These measures appear to have had some beneficial effect on healthcare costs within this system.

There has been discussion about expanding SHI to the uninsured or to the entire population (as is the case in Germany). However, there is a great deal of opposition from private insurers whose livelihoods would be compromised. It is unclear whether these systems would be more or less effective in negotiating costs for their members and the cost of management is also unknown.

National Health Plan

There have been several significant efforts made to promote the development of a National Health Plan (NHP) in this country. NHPs exist in Great Britain and Canada and have proven successful in promoting improved access, reduced costs and, in some cases, more generalizable health outcomes (such as infant mortality). Efforts to move toward an NHP in the U.S. were soundly defeated in the 1990s. However, many recognize the potential benefits of this approach, including broader coverage (for all members of society); stricter regulation of costs, services, and performance; and the removal of the profit-margin in our current system. Despite these improvements, many have recognized that this system would cost enormous amounts to initiate, would undermine our capitalistic approach, would reduce our incentives for technological advances, and would likely create behemoth bureaucracies to administer the system.

For a specific segment of our population, however, our country has developed a variation on the NHP theme: the DOD system for the military and the VA system for veterans. The military and DOD hospitals provide care efficiently, and cost-effectively for the millions of people they serve. There is limited or no cost to the populations served and healthcare is generally comprehensive, and increasingly preventive, and public health oriented. Expansion of these systems (e.g., increasing the population eligible for care) could allow the government to care for an increased number of people, in a cost-controlled environment, with established infrastructure and a tradition of quality care. Opponents might argue that offering broader coverage distracts the military medical system from its mission—caring for soldiers—and would dilute the role of the VAHS, which is to provide recompense for those who made physical sacrifices to serve their country. Further, expansion would require additional expenditures and would require revamping these systems for this higher volume of services. The validity of these arguments is unknown because these concerns are unstudied.

Direct Payment

Individuals pay out-of-pocket for about 15% of the cost of the U.S. HCS. An individual may choose to make direct payment for services not provided by or beyond the limits of their insurance. More commonly, out-of-pocket payments are made by individuals without HI who in need of urgent or emergent medical care. The proportion of these uninsured rose from 12.9 % in 1987 to 16.3% in 1998. Despite their numbers, they have no collective-bargaining power, so they are usually expected to pay the ‘going rate’ for care. Funds for these direct payments may come from savings, family, charities, or may be borrowed against future income. It has been established that most direct payments are made by the poorest individuals in our society, yet out-of-pocket payments are the largest source of revenue for healthcare providers. In 1998, they represented 97% of payments to hospitals, 84% of payments to physicians, and 68% of payments to nursing homes (Health Care Financing Administration 2000).

As employers decrease the proportion of costs they will assume and the government has fewer dollars to provide, it may be expected that direct payment or private pay will have to necessarily make-up the difference. Some argue this change would be positive and would overcome the moral hazard of HI, reaffirm the individual as the ultimate consumer (who will thereby learn to be more discriminating and cost-aware), and force providers to price their services at levels that individuals can afford. Consumers would be empowered

to pursue care that matches their pocketbook, and providers might have greater incentives to offer competitive prices. In the days before health insurance, physicians used a sliding scale fee to match income. Now with insurance it is a fixed rate based on what was negotiated. Change to private pay would, therefore, in some way reduce cost of care by discounting provider compensation—with unclear implications for practices.

On the other hand, this change to direct or private pay systems could also drive the HCS further towards a fee-for-service system. As an individual consumer, one has less clout to negotiate better prices (as a large HMO might). It would make collections more complex and costly, and would likely result in increased indebtedness across a greater segment of our society. Further, this would in no way improve the lot of the over 40 million people who are presently not covered by insurance, and are therefore considered self-funded payers (again, generally the poorest segment of society with the least ability to pay for healthcare services). Many might not be able to afford to pay, and they could potentially be denied services and possibly become sicker. In such a case, either the government would eventually pay for their care or they could be a societal financial loss due to decreased productivity with even worse potential outcomes.

Alternative Method of HCS Financing

Reflecting upon the options for healthcare financing (the promises and pitfalls of each possibility) produces no outstanding options to solve the problems of our complex healthcare system. This conclusion is based on a reasonable understanding of our culture, our history, American politics, financial stakeholders, fiscal realities and the complexity of our current system. Therefore, we provide a description of an alternative system (comprised of several components and not a single distinct method) that might improve our current system in a realistic fashion. The components of this alternative plan are listed below.

Improve and Universalize ‘Coverage’

It may be possible to provide coverage for all citizens by creating transportable Medical Savings Accounts (similar to Medical Savings Accounts or DCP accounts) that withdraw directly from pre-tax pay-check dollars (i.e., called “AmeriSave”). Employed individuals would contribute regularly (with matched contributions from their employers, including Federal contributions for US Military and Federal employees) until they reach a maximum of \$40,000. They would also make contributions for unemployed spouses and children, up to \$5,000 each until the age of 18. For the poor, contributions are made monthly by U.S. Government at a standard rate to achieve the same maximum level (\$40,000). Assuming that the presently uncovered would have at least episodic work throughout their life, the Government might only have to contribute \$10,000, \$20,000, or \$30,000 over several decades to provide adequate coverage. Because these funds are person-specific, while providing insurance against medical catastrophes, monthly payments out of these accounts (deductions) would not be necessary —UNLESS someone chose to buy HI with their account as a hedge against large medical expenses. Once deductions are made (for medical expenditures), the fund would be replenished with continued contributions.

Basic medical care would be purchased from these accounts, and certain care would NOT be covered. The money could not be used for anything other than healthcare service, could not be shared across accounts, and at death, this money would fold into a larger societal fund (see Catastrophic Insurance, below). People could choose where they would receive care and how much they would be willing to pay. Any medical expenses that exceeded the standard pay-scale (established by the Government, with experts from all sectors on the panel) by 20% would require the individual to pay the excess amount. (For example, if one wanted to go to the Mayo Clinic and it was 40% more than the ‘standard’ scale, the individual would pay the additional 20% out-of-pocket, plus the other 20% would come from, and would more rapidly reducing the individual’s AmeriSave account) Still, people *might* be more fiscally responsible with their healthcare choices, knowing that these were limited funds and would have to be replaced with personal funds later. People receiving governmental contributions to this account could be required to use the DOD/VA systems (see below) to help protect against indiscriminate spending or abuse. Mental Health coverage could also be paid out of this account.

Create a version of a National Health Plan

Another component is to expand the scope of the VAHS and DOD Military medical systems (called the “AmeriCare” system). This alternative could provide good-quality, evidence-based, public-health-oriented care at a fair price, and make it available to all persons,—especially, to the poor, homeless, Federal employees, military, veterans, students, and others without another form of health insurance. This system would continue and expand staffing with Military and VA employees and continue the relationship with academic centers (for mutual benefits of training opportunities and expansion of provider coverage). Expenses for care could be deducted from AmeriSave accounts, and the full cost of care for the consumers within this system would be covered (costs would necessarily match the ‘standard’ pay-scale). Funding in addition to AmeriSave dollars may be required for these hospitals (which would still care for AD soldiers and veterans), but the DOD and VAHS would continue to get coverage for their personnel/people, so that the budgets for the DOD/VAHS could accommodate this expense. Additionally, the increased size of this system would provide substantial leverage for negotiating with pharmaceutical and technology companies to get the best prices for this population. This measure, in and of itself, could significantly decrease HC costs.

In this option, the government would be assuming some increased fiscal responsibility (i.e., provide some coverage for the uninsured, and help prepare for the increasing elderly population). As a result, the government would likely have to reprioritize spending, increase some taxes, and use their resources more wisely. However, using Federal facilities to provide healthcare services would allow for some measure of control over an expanding segment of the healthcare market. Using best-evidence and well-defined guidelines could streamline care and maximize the outcome for each healthcare dollar spent, unlike what happens with present Medicare/Medicaid spending. The increased expense of this additional coverage would be most evenly spread across the US by drawing funds from tax dollars (from ‘the people’), but would also create a system that could be potentially accessible or beneficial to all.

Create a Catastrophic Insurance Plan

In anticipation of continued high-cost healthcare, we could create a supplemental catastrophic insurance plan called “AmeriPlan.” This could also be tax-based (with personal and corporate contributions) and could include the current Disability Insurance programs. It would serve to cover costs in excess of an individual's personal AmeriSave account and additional personal resources, and would help address workplace injuries and long-term disability. It could be managed by a Federal agency, but not be a part of the general governmental budget (to avoid reallocation problems). This agency would set standard fees for services, and persons needing better care (e.g., the "Nancy Reagan Nursing Home") would pay above the set standard reimbursement fee.

Create a fund for Public Health Initiatives

An additional feature would be to develop a new fund built to fund Public Health initiatives called it “AmeriHealth.” Its mission would be to develop preventative medicine programs, study screening, establish effective programs, and to distribute appropriate information and education to patients and providers. Conceptually, it would be a long-term investment in reducing medical expenditures in this country. It could be closely linked to the NIH and like-minded initiatives therein, and administered by the States. It would be also funded with taxes (personal and corporate input) with an escalating proportion of funds to AmeriPlan (25% of the total AmeriPlan initially with a 1% increase per year to a 40% cap). This would create a system to provide vaccinations, pre-natal vitamins, condoms, child safety seats, bicycle helmets, or whatever initiatives were deemed fundamental priorities for good public health. Some programs would be centrally managed; some programs would be executed through the private sector and states or local governments.

Preserve a role for Private Insurance

Finally, it would be important to allow people to buy health insurance with their own dollars or with AmeriSave dollars (while setting yearly limit). Purchasing insurance would be a hedge against disaster (insurers would accept liability), but also allow one to get access to any type of care desired (i.e., that is allowed by the insurance program) without worry about exceeding government standard rates. Additionally, one could get insurance to cover the fees that are in excess of government standards. This allowance would preserve a role for insurers. It could be offered by wealthy corporations as a fringe benefit to employees (e.g., "We'll get you the best care with our Insurance.") or could be bought by the average citizen who wants more options and control.

Impact

Adopting these measures would have some clear impact on several special interest groups. This program would expand coverage for the underinsured and potentially provide coverage to the many individuals without coverage. It might thereby improve access for the poor and give them more choice in making healthcare decisions. It would also promote access to public health and, hopefully, achieve improved outcomes for the generally underserved (i.e., improve infant mortality rates). It would not significantly impact the elderly, given their current access to Medicare. If a retiree had maximal

savings in his/her AmeriSave account, then additional payments (such as Part B of Medicare) would not be required. For those who are retired or unemployed with declining AmeriSave amounts, the government would make further contributions (meaning that medical dollars are accumulated during working years). Additionally, this program would not reduce the degree of access for the military service members/employees. These suggestions, however, would expand the military system and include ‘non-veterans,’ which might either improve the system by expansion, or prove detrimental by changing the exclusivity of access and perhaps causing competition for access. Federal employees would have greater freedom to access care, but could also obtain fairly-priced healthcare using AmeriSave dollars through the DOD/VAHS systems. Overall, the system should not cause dramatic decrements to care and might improve access to the underserved.

Conclusions

Though perhaps not entirely comprehensive, these alternative methods for financing healthcare might improve upon our present system. As illustrated, they incorporate various programs that already exist in our current system, and provide some of the purported benefits of other alternatives (i.e., the same freedom as DCPs, but removing the profit-motive and including people who are not employed). These alternatives increase government involvement without necessarily moving toward ‘socialized medicine,’ which is an unlikely solution for our culture and fiscal realities. These suggestions simply centralize some of the funding and augment/expand some of the more effective components of our current HCS. These proposals would also force corporations to maintain fiscal responsibility within our HCS, but would stabilize their contributions and overall liability—which could be a win-win scenario. These solutions do not address many other components of our HCS (medical malpractice; research; graduate medical education; immigrants; etc.), but they are a starting point and a direction for the future.