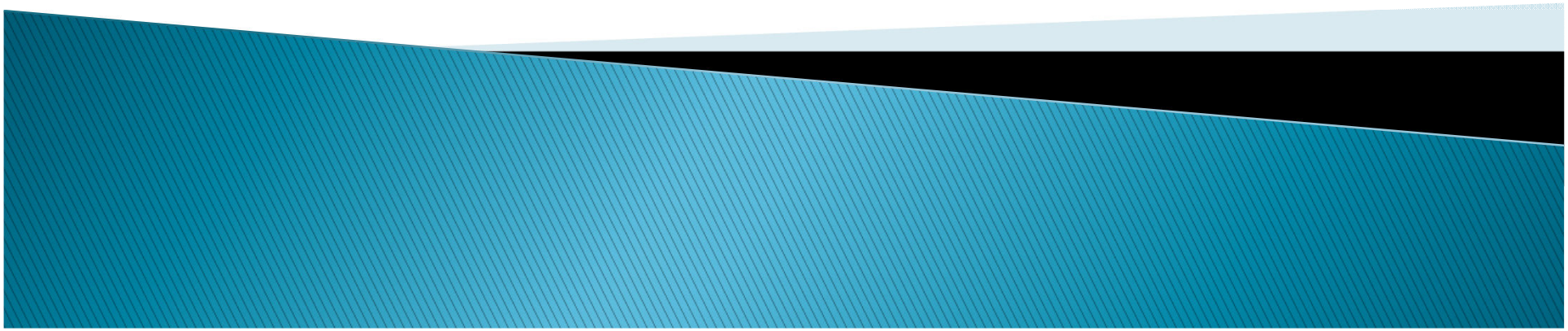
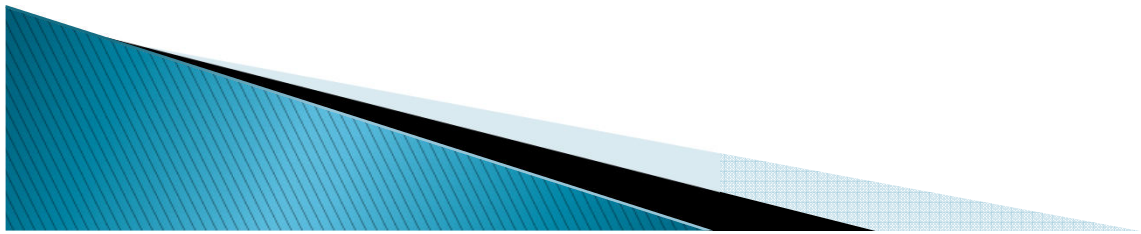
Evolution of Healthcare Delivery and Financing in US

By MRDTL Systems Pvt. Ltd.



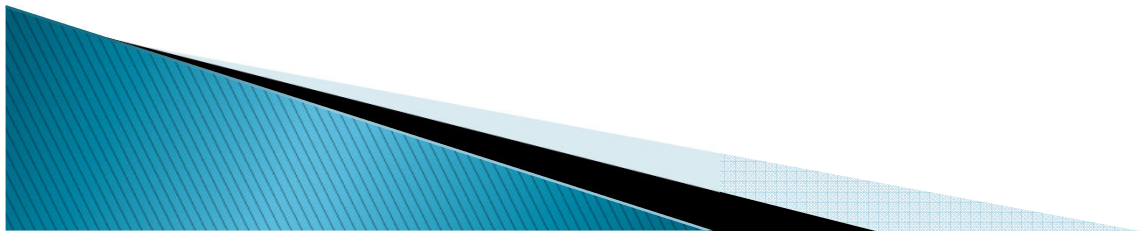
Agenda

- **Objectives**
- **Topics**
- **Concepts**



Objectives

- **After completing this module, you will be able to learn:**
  - **Define health plan.**
  - **Identify the major factors that influenced the evolution of healthcare delivery and financing in the United States.**
  - **Describe the role of the government in the development of healthcare delivery and financing.**
  - **List and describe some factors that limit accessibility to healthcare.**
  - **Discuss how the meaning of quality (as it relates to healthcare) has changed.**

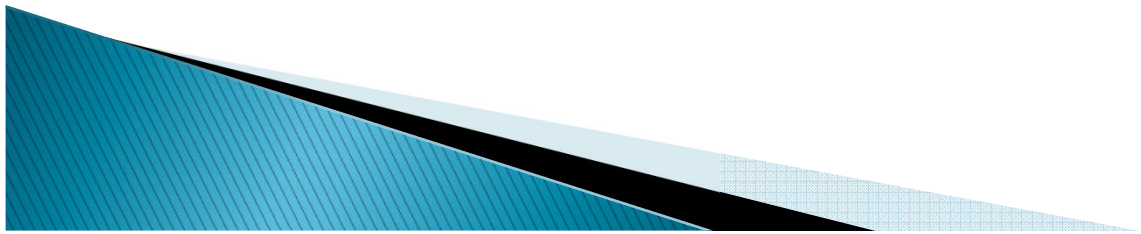


Topics

A	Evolution of Healthcare Delivery and Financing in the US
1	Historical Factors & HMO Act - 1973
2	Dual Choice Provision & Govt. Influence
3	Economic Factors & Social Factors
4	Cost Shifting
5	Basic Concepts – Benefits, Coverage, Risk & Insurance
6	Underwriting & Anti-Selection
7	Deductible & Co-insurance
8	Pre-existing Conditions & COB

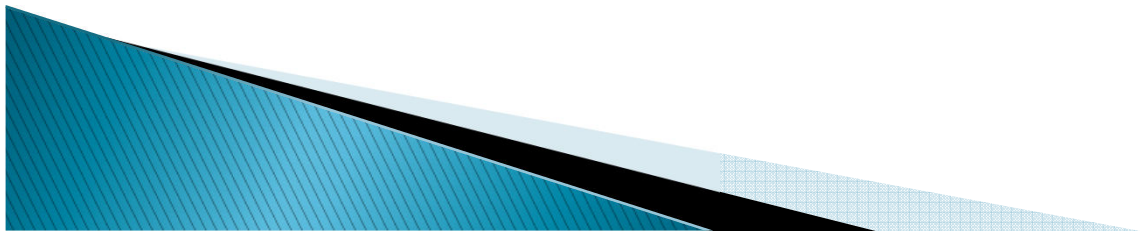
Historical Factors

- **Managed Care concept in US – since 1900s**
  - **Example – Prepaid Group Practice of 1910 - Healthcare system that offered plan members a wide range of medical services through an exclusive group of providers in return for a monthly premium payment.**
  - **Blue Cross Plans - since1929 - prepaid hospital care**
  - **Blue Shield Plans – since 1939 – reimbursement for physicians**
  - **IPAs – since 1954 – FFS plans**
  - **MCOs – Managed Care Organizations – 1900s – small fraction of business holding.**
  - **Dramatic increase in share , more than 200 million individuals by Jan 2004 covered by Health Plans (MCOS)**



HMO Act - 1973

- **Purpose:**
  - **The HMO Act of 1973 was designed to reduce healthcare costs by increasing competition in the healthcare market and to increase access to healthcare coverage for individuals without insurance or with only limited benefits.**
- **Features:**
  - **Federal qualification requirements**
  - **“Dual choice” provisions**
  - **Federal development grants and loans**
  - **Exemption from state laws**
- **Important : This act established a process by which HMOs could obtain federal qualification**

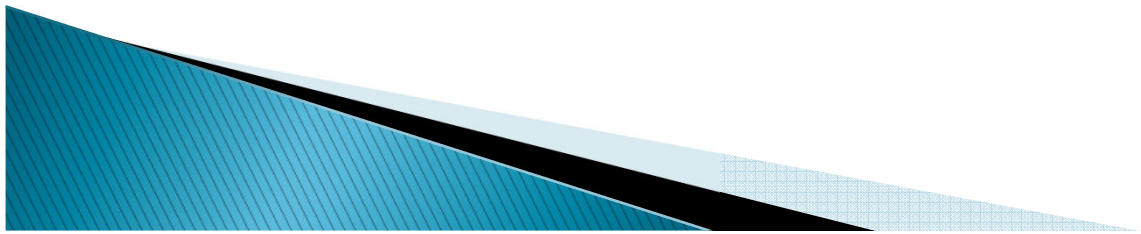


Dual Choice Provision

- *"Dual choice" provisions required , employers that offered healthcare coverage to more* **than 25 employees to offer a choice of traditional indemnity coverage or managed healthcare coverage under either a closed-panel HMO or an open-panel HMO.**

- **Federally qualified HMOs that wished to be considered by an employer as a healthcare coverage option under the "dual choice" provisions were required to submit a formal request to the employer.**

- **HMO Act – Huge changes between – 1976 and 1996 e.g. Dual Choice Provision repealed in 1995**

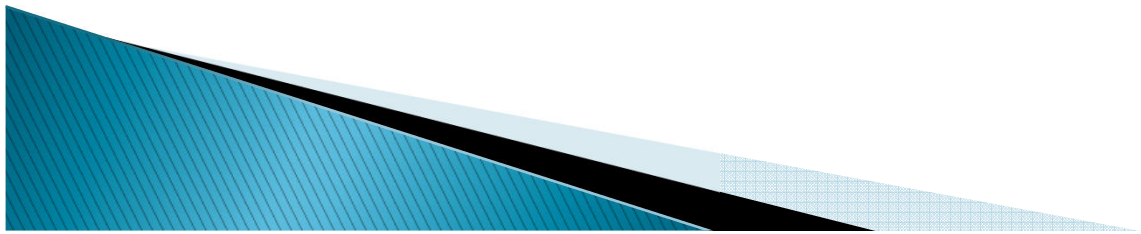


Govt. Influence & Economic Factors

- PPO, POS,PHOs and Carve-Outs – new products launched due to healthy competitiveness.
- MEDICARE , MEDICAID, FEHBP,SCHIP etc
- The National Committee for Quality Assurance (NCQA) began to accredit HMOs in 1991 and since then has developed a variety of quality measurement tools, including the Health Plan Employer Data and Information Set (HEDIS®).
- Reasons for the increases in the cost of medical care?
  - Inflation
  - Rapidly expanding technology
  - Increases in medical malpractice lawsuits
  - Consumer expectations
  - “Unnecessary” treatment
  - Lack of incentives to control medical costs

Social Factors

- **Maturing population – Aging population, Chronic Diseases, Long term care**
- **Access to services**
- **Poor Health Risks**
- **Uneven distribution of medical services**
- **The Quest For Quality – increasing consumer expectations.**

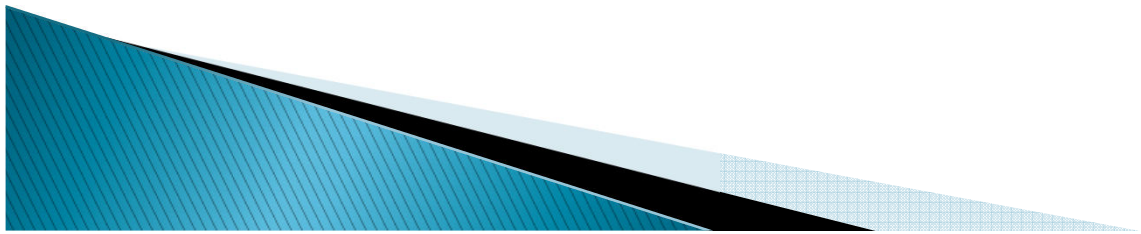


Cost Shifting

- **The Neptune Hospital provides medical care to paying patients, as well as to people who either have no healthcare coverage and cannot afford to pay for the care by themselves or who receive services at reduced rates because they are covered under government-sponsored healthcare programs.**

- **To subsidize its treatment of these patients, Neptune has a practice of spreading these unreimbursed costs to its other paying patients.**

This practice is known as Cost Shifting.



Basic Concepts – Benefits, Coverage & Insurance

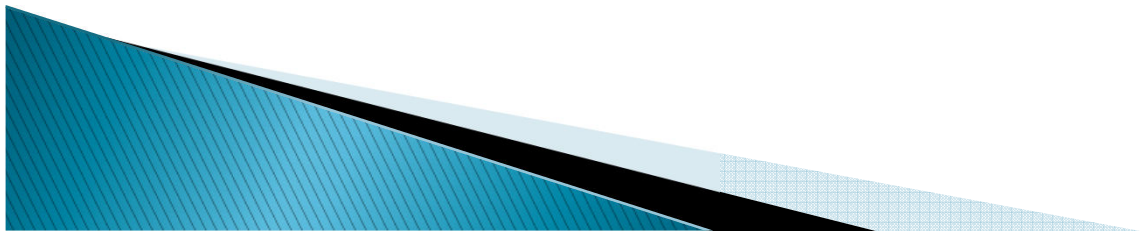
- Till 1988 – Traditional indemnity Plans market share – 71 % (employer sponsored group health plan)
- By 2003 – it is just 5 % while Health plans – 95 %
- Traditional Group Indemnity Plans -

  Policy Holder – Employer

  Insured – Group Member

  Premium – Periodic payment amount

- *Fee-for-service (FFS) payment system* - The system in which the insurer will either reimburse the group member or pay the provider directly for each covered medical expense after the expense has been incurred.
- This benefit payment system is a distinguishing characteristic of traditional health insurance plans.

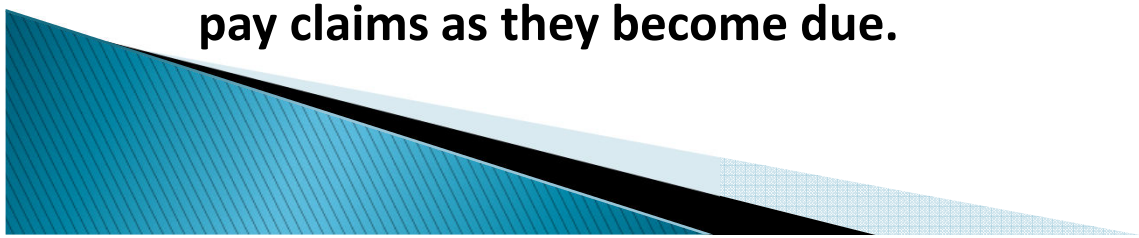


Risk & Insurance

- **Insurance – It is a way of guarding against the financial risks that are always present in life. Health insurance pays specific benefits if an insured person becomes ill or is injured.**

- **Risk - It exists when there is uncertainty about the future. Insurers provide the medium for bringing together a large number of people who have similar risks of economic loss (e.g. the economic loss caused by paying medical expenses for treating an illness).**

- **Loss Rate - the number and timing of losses that will occur in a given group of insured's while the coverage is in force. An insurer must be able to predict this loss rate(using surveys) to determine the proper premium rate to charge for each insured so that adequate funds are on hand to pay claims as they become due.**



Underwriting & Anti-Selection

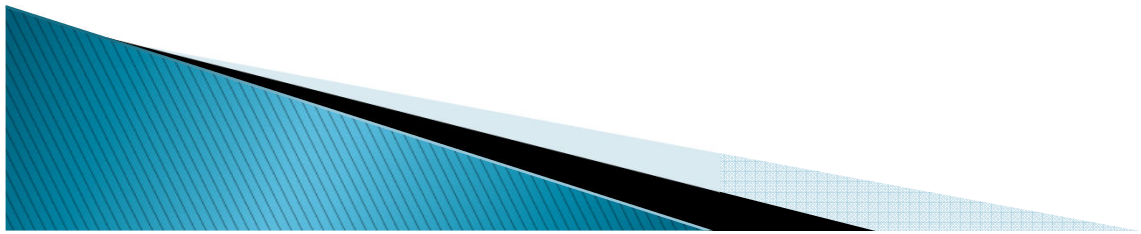
- **Underwriting (*selection of risks*) - The process of identifying and classifying the potential degree of risk represented by an insurance applicant is called underwriting.**
- **Anti-Selection – the people who are most likely to have claims or losses are also the most likely to apply for insurance. If the insurer does not consider the possibility of anti-selection when reviewing applications for insurance, it may issue coverage to a relatively large number of these people. Then the insurer would experience more losses, and would have to pay out more benefits than it had expected when it decided how much to charge for the coverage.**
- **Evidence of insurability - for health insurance usually consists of documents and reports that provide information about the applicant's current health, health history, and any activities that affect the applicant's health.**

Deductible & Co-insurance

- **Deductible - is a flat amount that a group member must pay before the insurer will make any benefit payments.**

- **In other words, if the deductible were $250, the insured group member would pay out-of pocket the first $250 of medical expenses incurred that year before the insurer would begin to cover any medical expenses.**

- **Cost Sharing – Coinsurance is one method of cost sharing. After the group member has paid the deductible amount, most policies also require the group member to pay a stated percentage of all the remaining eligible medical expenses. This method of cost sharing is known as *coinsurance*.**

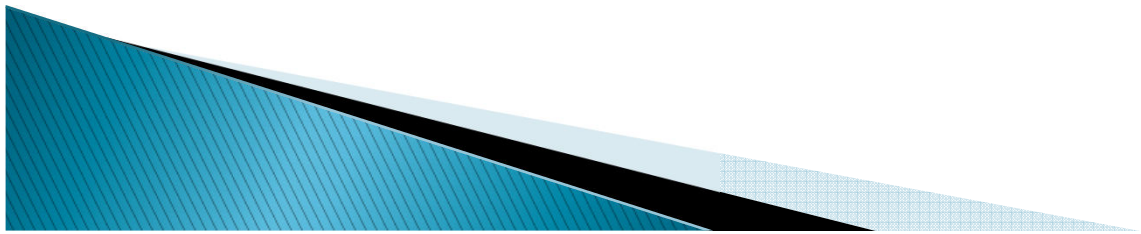


Pre-existing Conditions & COB

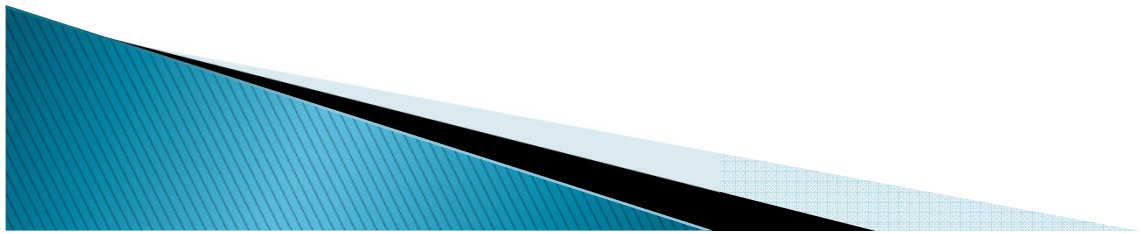
- **Pre-existing Conditions - is usually defined (in group policies) as a condition for which the individual received medical care during the three months immediately prior to the effective date of coverage.**

- **Coordination of Benefits (COB) - Under the COB provision, the primary plan pays the full benefit amount payable under the plan and the secondary plan pays the difference between the amount of expenses occurred and the amount paid by the primary plan.**

- **Currently there is more Emphasis on Preventive Care and Wellness Programs**



Questions?



Thank You!