Understanding the U.S. Healthcare System: Incentives, Motivations and Opportunities

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1Federal Reserve Bank of Chicago; any views expressed in this presentation do not necessarily reflect those of the Federal Reserve Bank of Chicago or the Federal Reserve System.
Overview

- Goal: institutional background on the US health care system
  1. Where people get their coverage
  2. Incentives the coverage provides for key actors: insurers, patients, and providers
  3. How changing incentives for providers can affect patient outcomes
    - New paper: increasing Medicaid payments to primary care doctors associated with better access, health, and school attendance
US Health Care: Coverage

Source: CMS, National Health Expenditure Fact Sheet, 2016
US Health Care: Coverage

Source: CMS, National Health Expenditure Fact Sheet, 2016
US Health Care: Employer-Sponsored Insurance (ESI)

- 49% of US population (49% of children)
- Historical roots in wage freezes during WWII and tax policy
  - ESI exempt from taxation, so cheaper to get insurance through employer than in other ways
- Covered either through own job or as a dependent
- Average employer contribution 82% of total premiums for individuals, 70% for families
- Lots of variation in generosity, plan type
US Health Care: Coverage

Source: CMS, National Health Expenditure Fact Sheet, 2016
US Health Care: Medicaid / CHIP

- Medicaid + CHIP: 19% of US population, 38% of children
- CHIP provides health insurance to mid/low income children
  - Some states incorporate CHIP into Medicaid, others administer separately
  - 49 states cover children to at least 200% FPL (19 to 300%)
- Eligibility for adults depends on Medicaid expansion status
  - Non-expansion states: categorical eligibility (low income children and parents, pregnant women, disabled)
  - Expansion states: up to 138% FPL for adults
- Some states pay providers directly, others subcontract to private companies (Medicaid Managed Care)
Source: CMS, National Health Expenditure Fact Sheet, 2016
Federal health insurance for people aged 65+ or with permanent disabilities—covers 14% of the US population

- 17% under 65 with permanent disabilities
- 20% Medicaid dual eligibles

Medicare benefits

- Part A/B: traditional coverage for hospital/physician services
- Part D: Drug coverage
- Part C: Medicare Advantage—private, usually Part A/B/D (33% of beneficiaries)

Traditional Medicare has high cost sharing, supplemental insurance common ("Medi-Gap")
US Health Care: Coverage

- Employer-sponsored
- Medicaid + CHIP
- Medicare
- Non-group
- Military/Veterans
- Uninsured

Source: CMS, National Health Expenditure Fact Sheet, 2016
US Health Care: Non-Group Insurance

- 7% of US population (6% of children)

- Individuals/families that purchased plans through an ACA marketplace + purchased insurance outside ACA markets

- Premium tax credit reduces marketplace enrollees premiums
  - Eligibility: 1-4x Federal Poverty Level, no access to affordable ESI/Medicare/Medicaid/CHIP

- Cost sharing subsidies: reduce out of pocket costs—deductibles, copayments, and coinsurance
  - Eligibility: 1-2.5x Federal Poverty Level, silver plan
US Health Care: Coverage

Source: CMS, National Health Expenditure Fact Sheet, 2016
US Health Care: the Uninsured

- ACA increased coverage by expanding Medicaid and providing Marketplace subsidies

- But uninsured remain: 9% of US population (5% of children)

- Cost still most common barrier to coverage
  - Not all uninsured eligible for free or subsidized coverage
  - Some not aware of coverage options, barriers to enrollment
  - Low income, working families, nonelderly adults

- Uninsured adults more likely to postpone or forgo health care; when do seek care, high bills can quickly become medical debt
• Health insurance companies determine a lot of the payment landscape

• Purpose of health insurance: help people pay for care, protect from unexpected expenses

• Insurers design incentives for patients and providers, such that:
  • There is demand for the plan—people will sign up for it
    • Financial coverage for beneficiaries is sufficient
    • Enough providers participate to keep the beneficiaries happy
  • Patient cost sharing and provider payments designed to discourage use of expensive, wasteful care
Financial Incentives for Patients

Difficulty of insurance design on the patient side:

- Provide for unexpected health care needs and minimize costs
  - People who choose generous plans likely require more care
  - As insured face a smaller share of their medical care costs, consume more care

- Plan types: PPO/HMO/high deductible/narrow network plans vary out-of-pocket costs in different combinations
  - Network: the set of providers who accept your insurance
  - Premium: monthly payment to be enrolled
  - Deductible: full amount paid by enrollee up to this amount
  - Co-insurance: fraction of costs insurer pays, after deductible
  - Copay: amount paid per visit
Financial Incentives for Providers

On the provider side:

- Want to incentivize providers to give the right amount of care, taking into account the profit incentives of providers

- Traditional provider payment is based on volume, provider paid a fixed amount for each service provided (fee-for-service)
  - Incentives: pay based on volume/intensity of services provided

- Recent push to dampen volume incentivizes, and to tie provider payments to measures of performance or quality

- Two biggest provider payment categories: hospitals and doctors
Provider Payment: Hospitals

- **Main payment systems:**
  1. Fee-for-service: fixed amount for each service
  2. By diagnosis (DRGs): hospital paid based on diagnosis, regardless of how much money actually spent on treatment
  3. Per diem: based on number of days in hospital

- **Private insurers:** DRGs/per-diem/fee-for-service

- **Medicaid:** DRGs or per-diem, varies by state

- **Medicare:** DRGs, also hospital pay-for-performance
  - Hospital Value-Based Purchasing Program (VBP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital-Acquired Condition (HAC) Reduction Program.
Provider Payment: Doctors

- Historically paid fee-for-service—basis of payment is per service provided

- Rise of alternative payment models to control costs
  - Capitation: basis of payment per patient per time period
  - Bundled payments: episodes of care as the base of payment
    - Eg. an outpatient procedure plus all services provided during a window around the procedure
  - Pay-for-performance: tie payments to performance — varied
    - Eg. bonus at end of year if exceed thresholds on quality measures, with higher bonuses for more complex patients

- Bulk of revenue still from fee-for-service
Provider Payment: Doctors
Payment-method diversity growing, still small share of revenue (AMA)
Many studies on the role of physician payment on treatment choice and intensity, technology adoption

Alexander and Schnell (2018): Does increasing Medicaid payments to physicians improve access and health among beneficiaries?

Significant disparities in access to care between publicly and privately insured in US

- 65% of physicians accepting new Medicaid patients; 88% accepting new patients with private insurance (2009)
- Lower payments... also payment delays, complex program requirements, concerns managing care of difficult patients
• ACA primary care rate increase: states required to raise Medicaid payments to Medicare levels for primary care services
Data: Medicaid primary care physician payments

• Use these large changes in Medicaid payments to primary care doctors to see if increasing payments associated with better access/health

• Higher payments associated with . . .
  • Increased program participation among doctors
  • More office visits; better health among beneficiaries
  • Fewer days of missed school
Access and Health Increase with Payment Increase

A. Full Sample

- Office Visit in Past Two Weeks
- Health: Not Poor or Fair
- Health: Excellent or Very Good

B. Child Subsample

- No Trouble Finding MD
- Usual Place of Care
- <14 School Days Missed (Age ≤ 10)

C. Adult Subsample

- Accepting New Patients
- Accepts Patient’s Insurance
- Work Days Missed

Increase in Medicaid Payments
Access and Health Increase with Payment Increase

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Accepting New Patients

Accepts Patient’s Insurance

Work Days Missed

Estimated Coefficient

\[ \begin{align*}
\text{Office Visit in Past Two Weeks} & : -0.005, 0, 0.005, 0.01 \\
\text{Health: Not Poor or Fair} & : -0.01, -0.005, 0, 0.005, 0.01 \\
\text{Health: Excellent or Very Good} & : -0.005, 0, 0.005, 0.01 \\
\text{No Trouble Finding MD} & : -0.01, -0.005, 0, 0.005, 0.01 \\
\text{Usual Place of Care} & : -0.01, -0.005, 0, 0.005, 0.01 \\
\text{<14 School Days Missed (Age ≤ 10)} & : -0.01, -0.005, 0, 0.005, 0.01 \\
\text{Accepting New Patients} & : -0.01, -0.005, 0, 0.005, 0.01 \\
\text{Accepts Patient’s Insurance} & : -2, -1, 0, 1, 2 \\
\text{Work Days Missed} & : -0.01, -0.005, 0, 0.005, 0.01
\end{align*} \]
Conclusion

• Search for reforms that decrease spending and/or improve outcomes—lots of policy experimentation and space to play with incentives

• Suggestive evidence from Alexander and Schnell (2018):
  • Increasing Medicaid payments to doctors improves access for publicly insured (no crowd out for privately insured)
  • Also improvements in self-reported health, school attendance

• Physician payment promising policy lever to increase utilization and improve outcomes among low-income populations
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• Physician payment promising policy lever to increase utilization and improve outcomes among low-income populations

• But: changing payment policy does not always work as intended—crucial to seriously consider details of implementation, evaluation, and scaling
Health Care Spending: Where Does It Go?

Source: CMS, National Health Expenditure Fact Sheet, 2016