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

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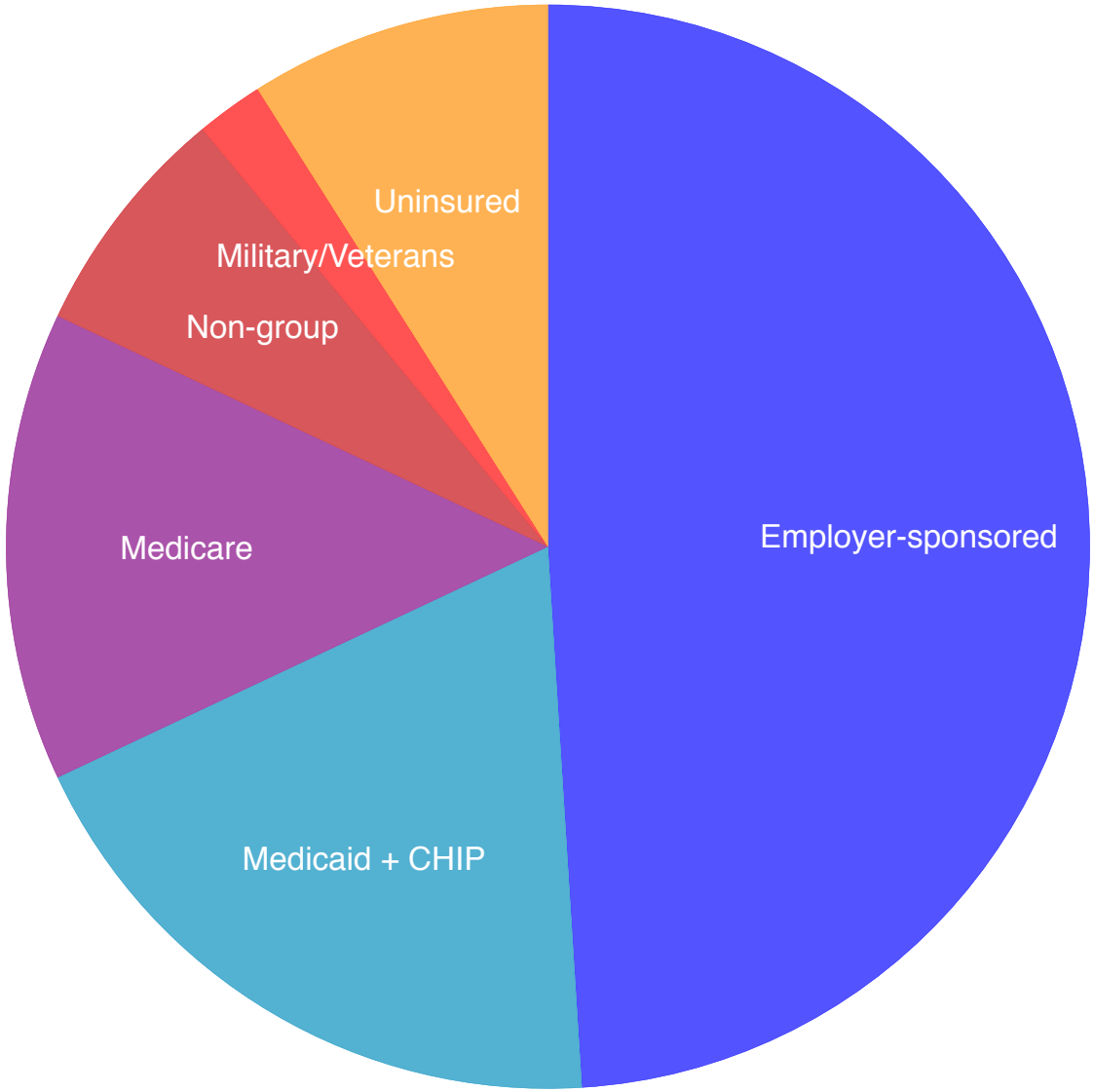
[1]Federal Reserve Bank of Chicago; any views expressed in this presentation do not necessarily reflect those of the Federal Reserve Bank of Chicago or the Federal Reserve System.

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

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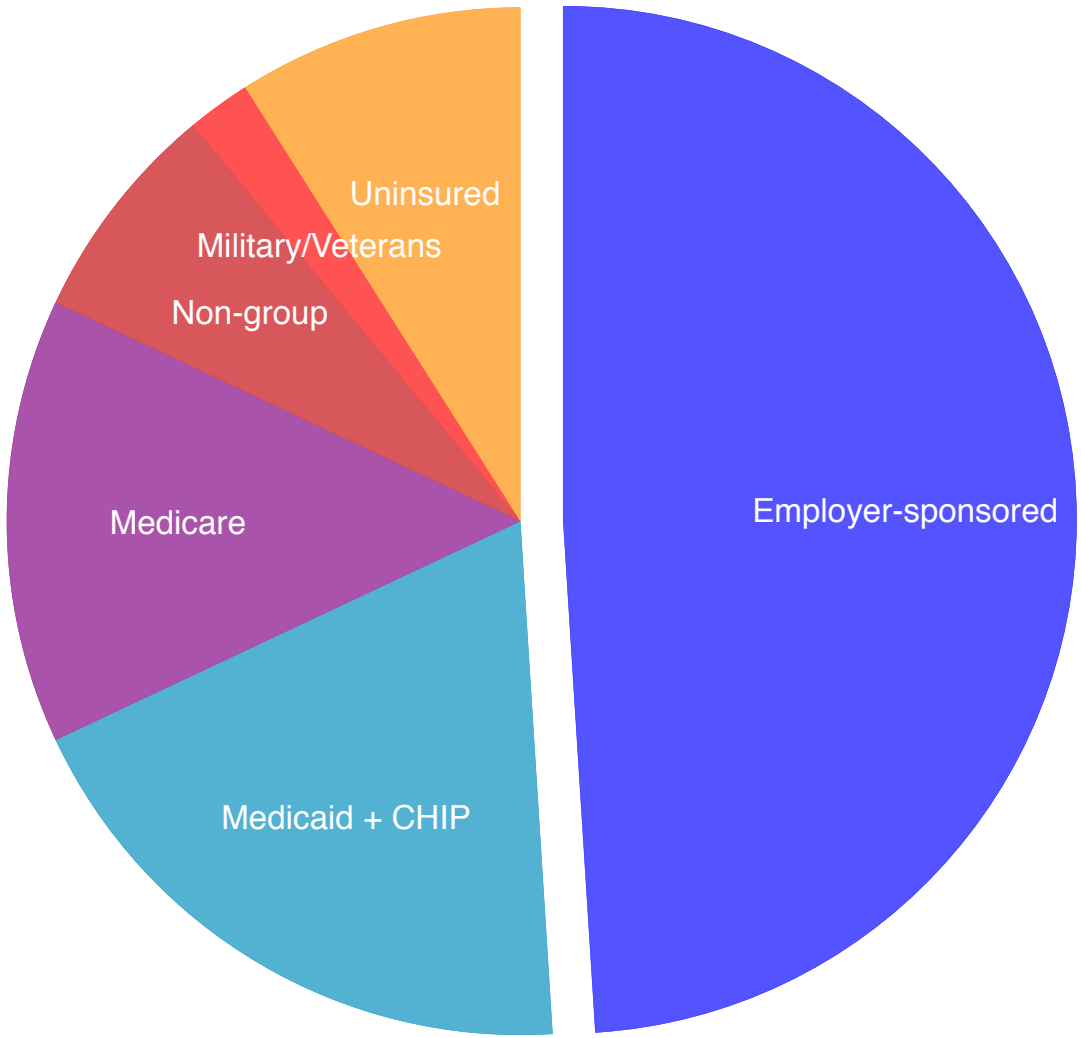
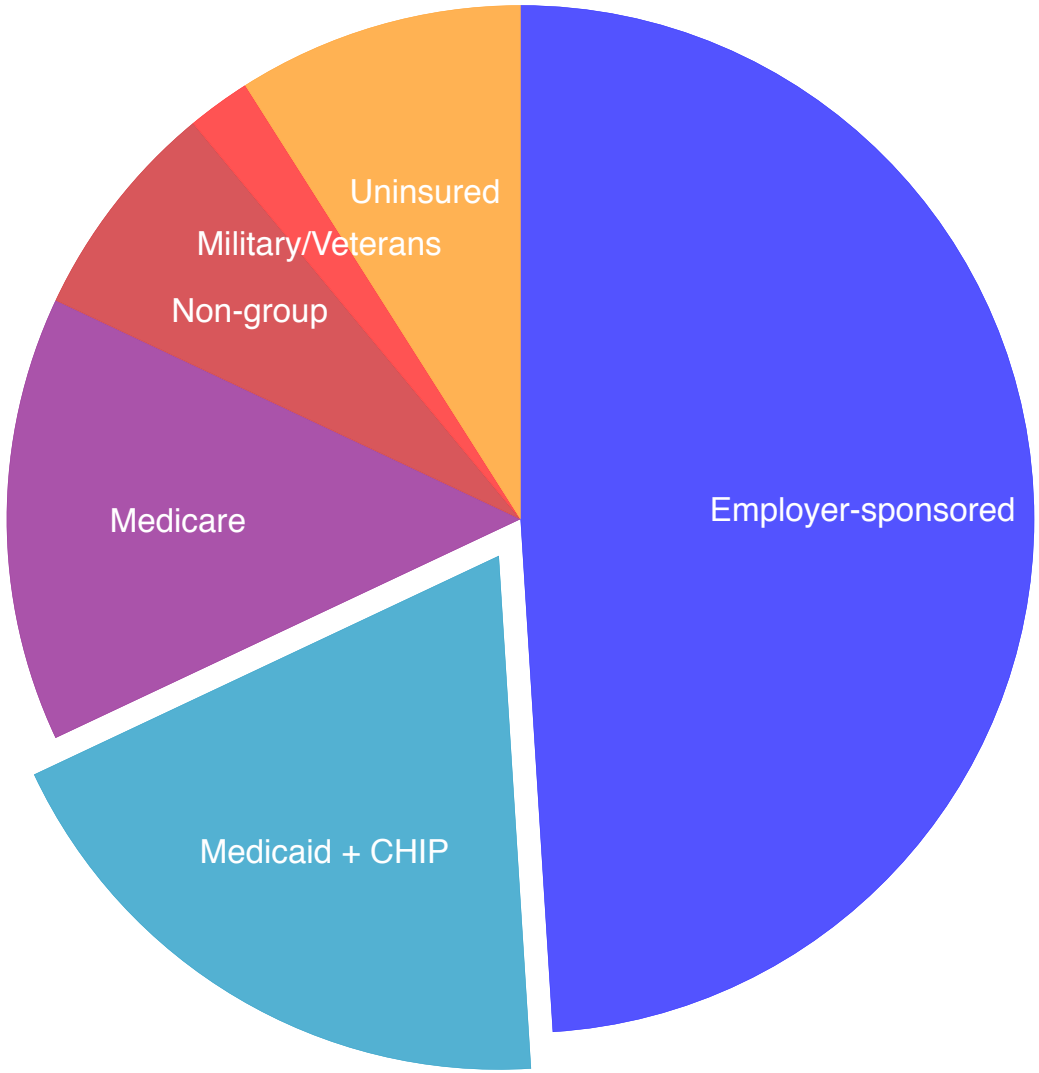


Source: CMS, National Health Expenditure Fact Sheet, 2016

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)

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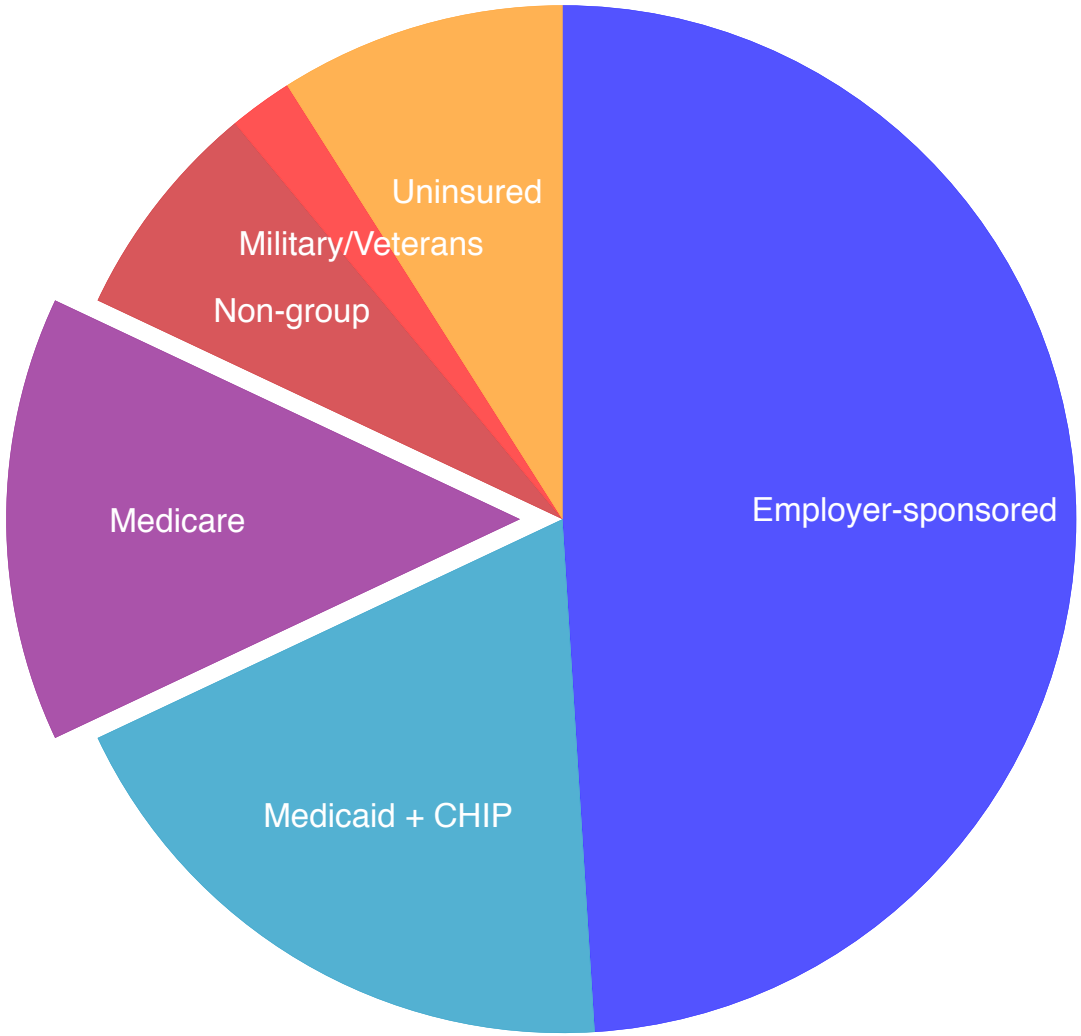
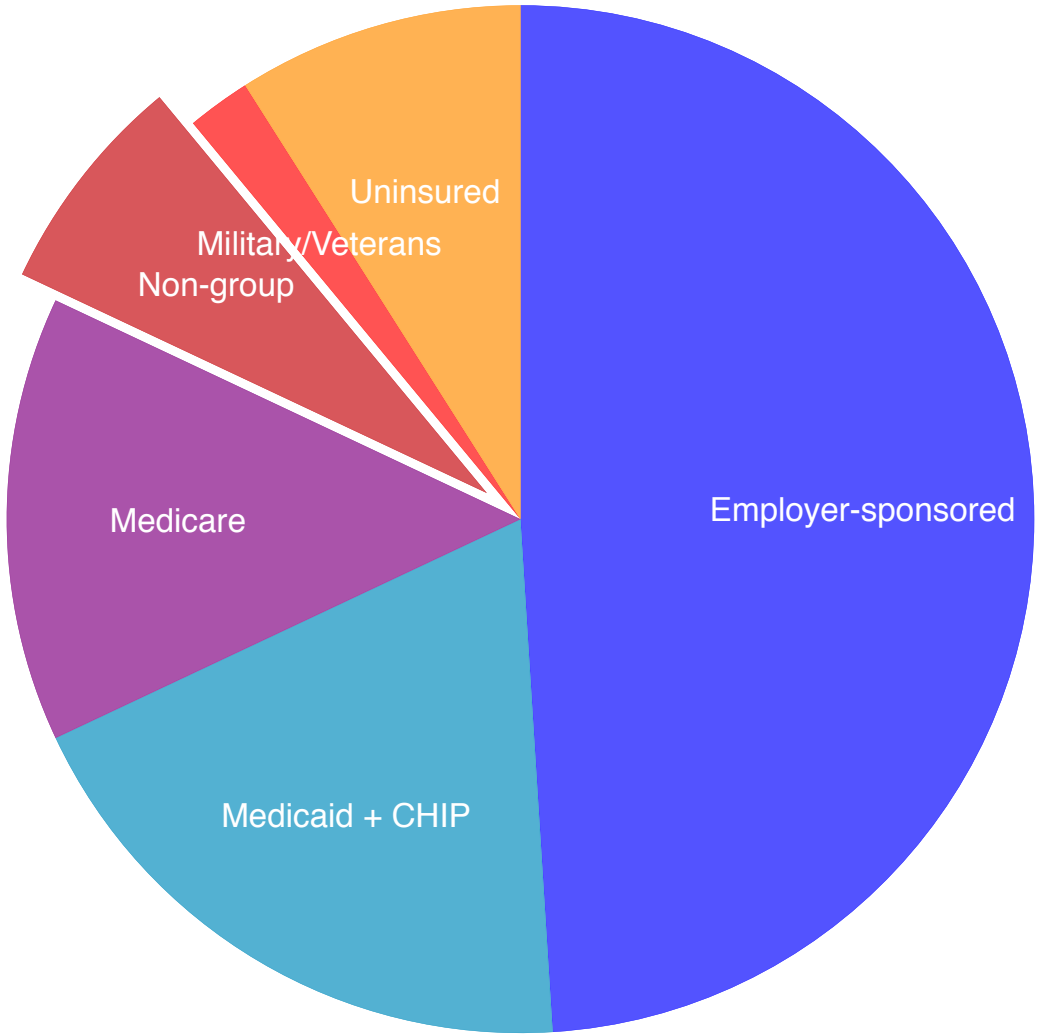


Source: CMS, National Health Expenditure Fact Sheet, 2016

US Health Care: Medicare

- 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



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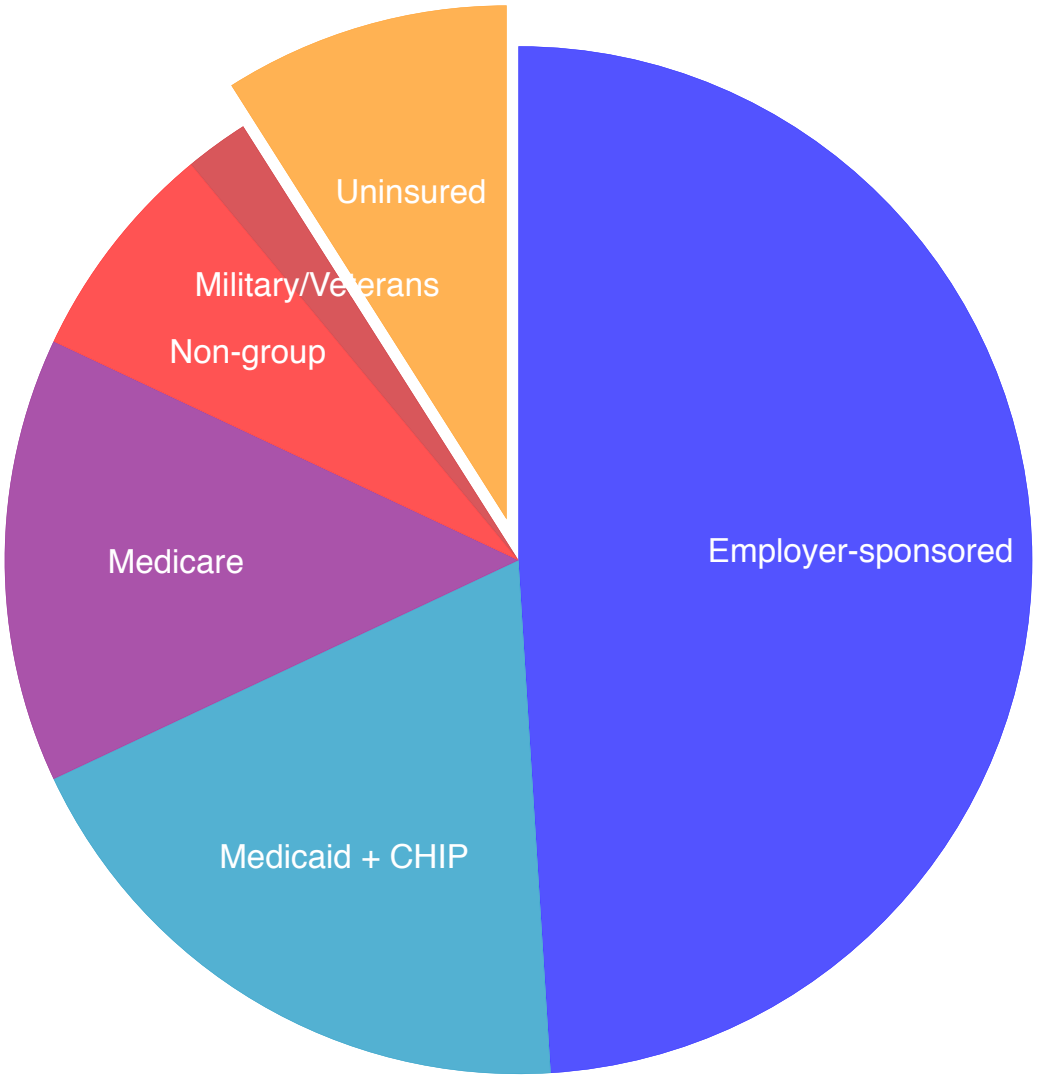
US Health Care: Non-Group Insurance

- 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
  - Eligbibility: 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
  - Eligbibility: 1-2.5x Federal Poverty Level, silver plan

US Health Care: Coverage



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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

Financial Incentives: How Does Everyone Get Paid?

- 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

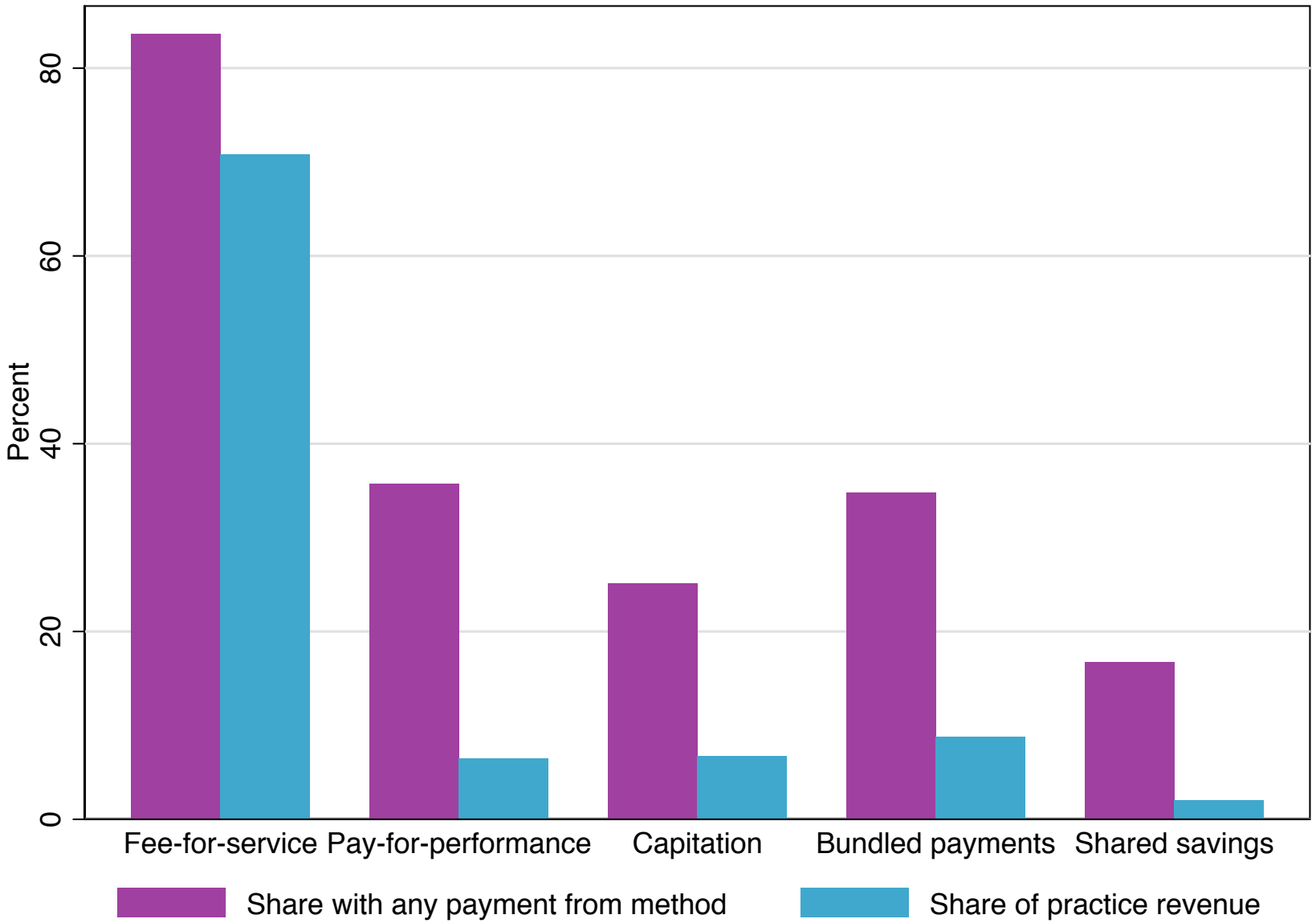
- Private insurers: DRGs/per-diem/fee-for-service
- Medicaid: DRGs or per-diem, varies by state
- Medicare: DRGs, also hospital pay-for-performance
  - Hospital Value-Based Purchasing Program (VBP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital-Acquired Condition (HAC) Reduction Program.

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)

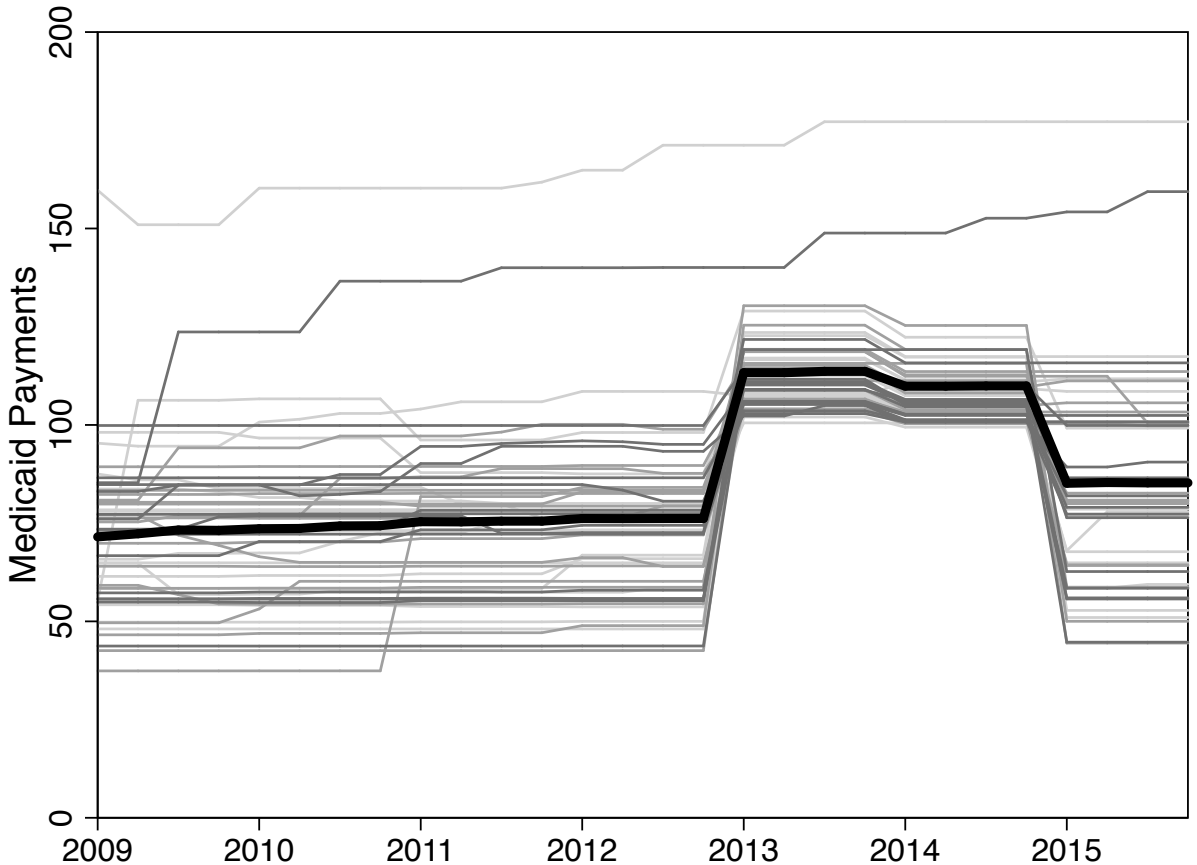


Provider Payment and Access to Care

- 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

Alexander and Schnell (2018)

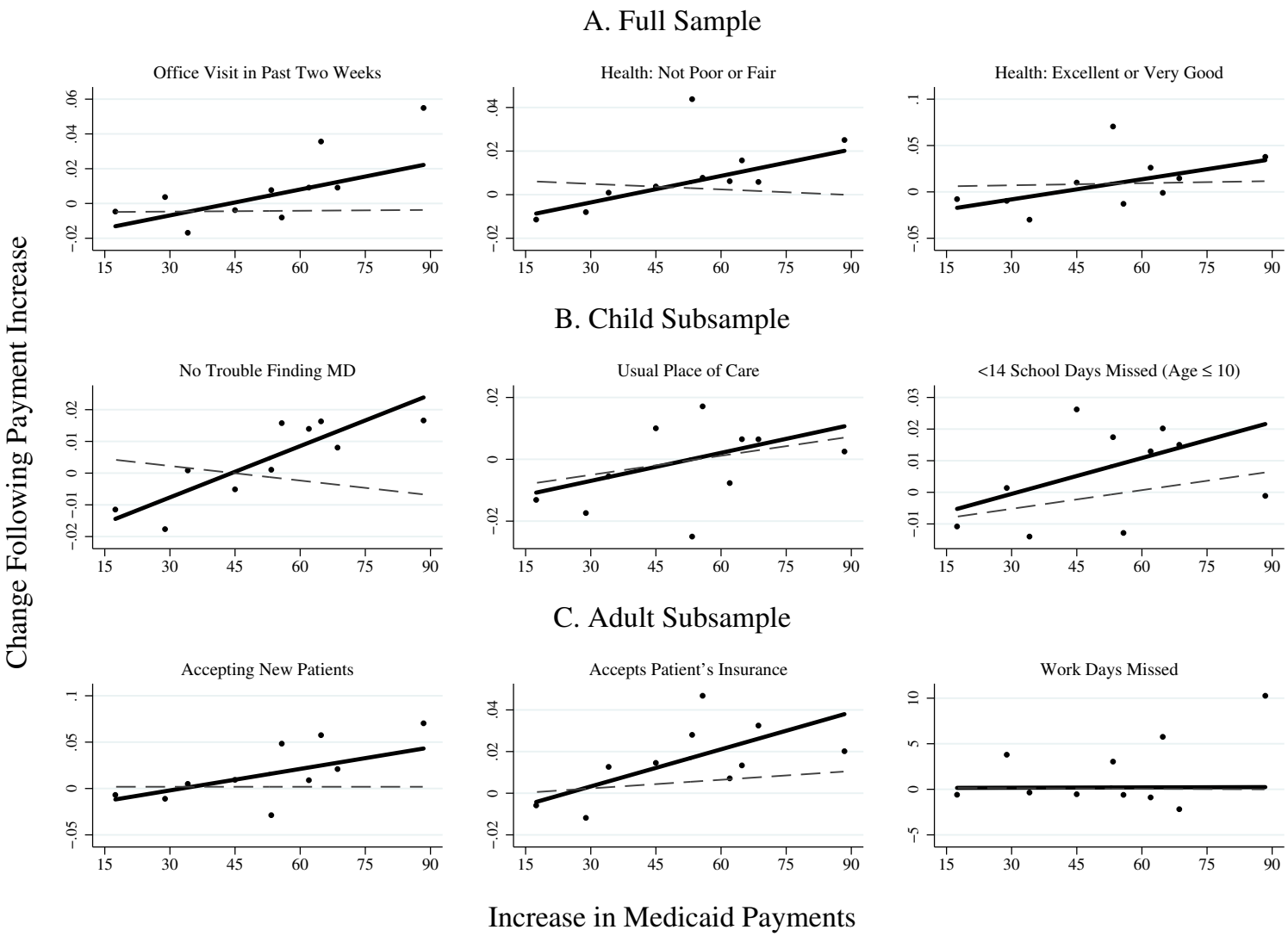
- ACA primary care rate increase: states required to raise Medicaid payments to Medicare levels for primary care services



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



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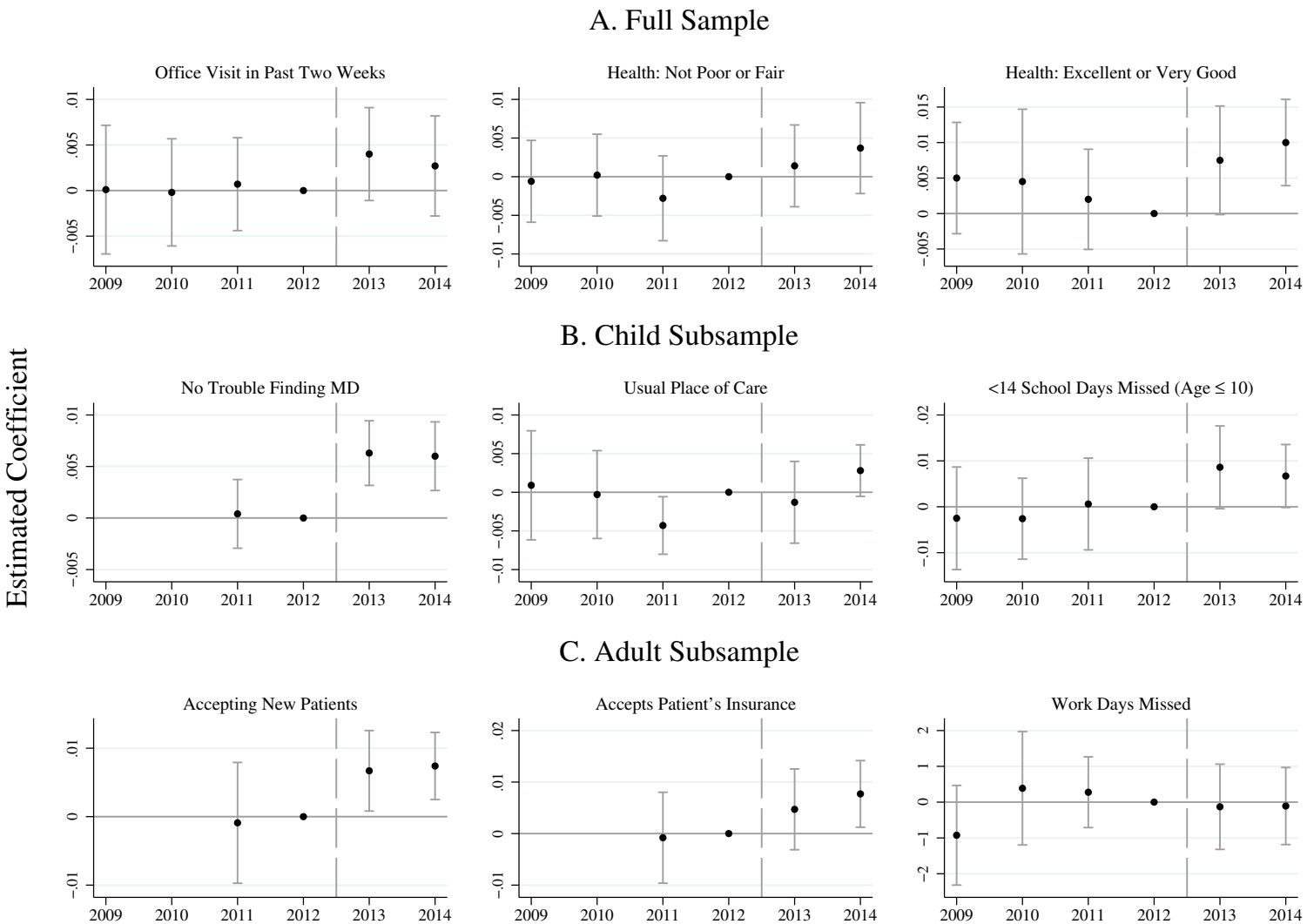

Conclusion

- 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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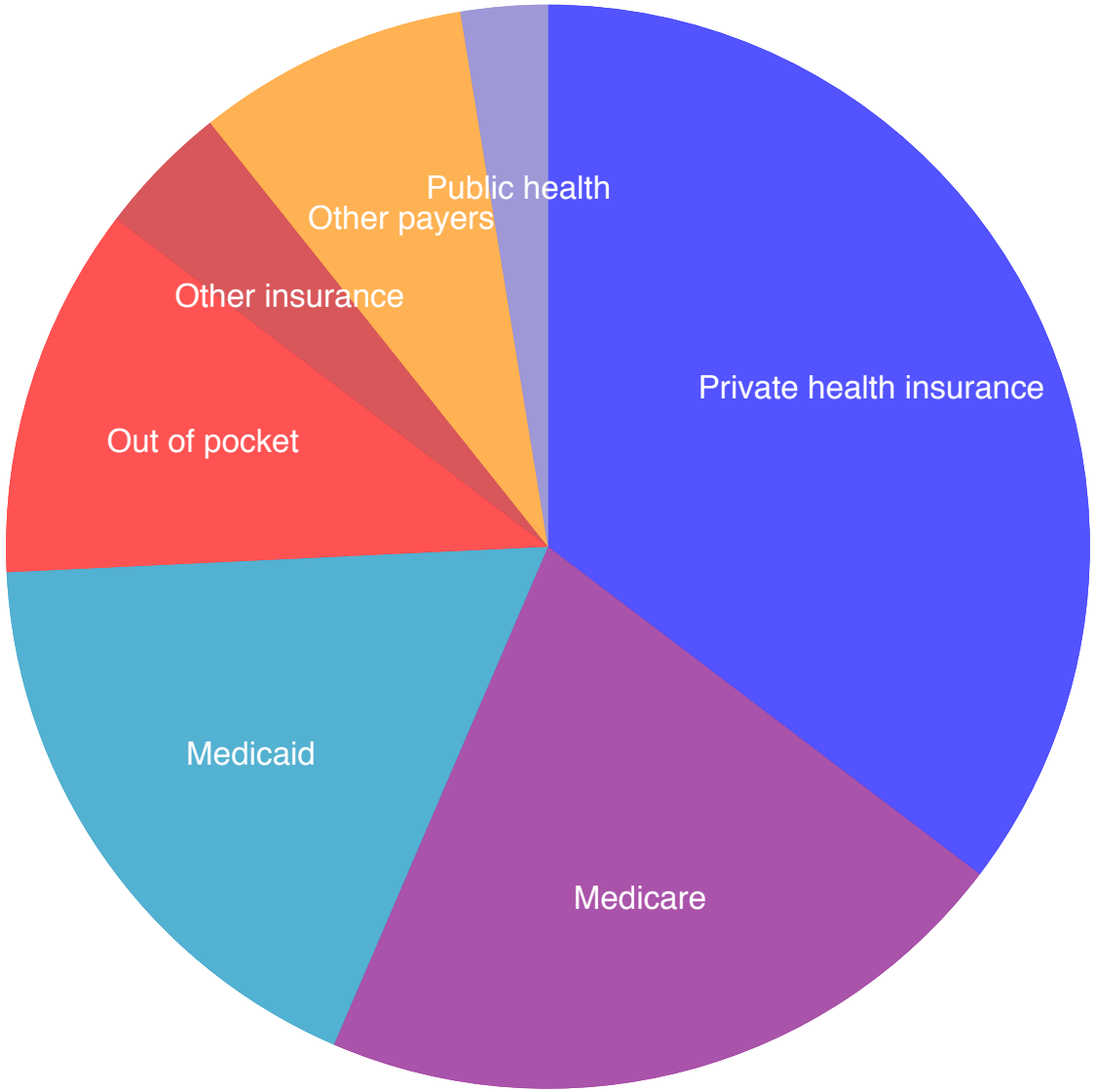
  - Also improvements in self-reported health, school attendance
- Physician payment promising policy lever to increase utilization and improve outcomes among low-income populations
- But: changing payment policy does not always work as intended—crucial to seriously consider details of implementation, evaluation, and scaling

Health Care Spending: Where Does It Go?



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