The Office of the National Coordinator for Health Information Technology

Audio Transcript

Introduction to Health Care and Public Health in the U.S. Financing Health Care, Part 1 Lecture a

Health IT Workforce Curriculum Version 4.0/Spring 2016

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Welcome to Introduction to Health Care and Public Health in the U.S.: Financing Health Care, Part 1. This is lecture a.

This component, Introduction to Health Care and Public Health in the U.S., is a survey of how health care and public health are organized and how services are delivered in the U.S. It covers public policy, relevant organizations and their interrelationships, professional roles, legal and regulatory issues, and payment systems. The component also addresses health reform initiatives in the U.S.

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The learning objectives for Financing Health Care, Part 1 are to:

- Describe the history and role of the health insurance industry in financing health care in the United States, including Federal laws that have influenced the development of the industry
- Explain the importance of the health care industry to the U.S. economy and the role of financial management in health care

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- Describe the models of health care financing found in the U.S. and in selected other countries
- Explain the differences among various types of private health insurance and describe the organization and structure of network-based managed care health insurance programs

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- Describe the various roles played by government as policy maker, payor, provider, and regulator of health care
- And, finally, describe the organization and function of Medicare and Medicaid

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This lecture provides a brief history of the health insurance industry in the U.S. and discusses the role played by the government and other factors that shaped the current system. It will also make the distinction between privately-funded and publically-funded, or government, health insurance.

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The history of the health insurance industry in the United States is relatively recent. In the late 19th and early 20th centuries, medical care was provided primarily at the patient's or the doctor's home. The cost of care was borne by the patient or charities. The view of medicine as a science grew as advancements in such areas as infectious disease and surgery improved the lives and health of the population. Early in the 20th century, the American Medical Association began to standardize the training that new doctors received, and the quality of care improved. Medical care for illness began to move from the home to the doctor's office and hospitals. During this time, commercial health insurance was not available, as insurers could not predict the risk or cost due to

the unpredictability of health. There was also what was called the moral hazard, the risk that people would behave differently regarding their health, knowing that part of the risk would be paid for by someone else.

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One of the early health plans started in 1929 when 1300 Dallas school teachers formed an association and contracted with Baylor Hospital for twenty-one days of hospitalization annually for six dollars per year per school teacher. At the urging of the American Hospital Association, other hospitals around the country entered into similar agreements with local organizations. These became known as hospital service plans and were exempt from insurance regulations in most states. The number of associations grew, and by 1939, nearly 3,000,000 people belonged to a hospital payment plan. These plans would eventually come together and form the organization known as Blue Cross.

Fearing loss of control over their patients, physicians began to form their own associations. In 1939, California physicians formed a prepaid plan that covered physician services. Other physician groups around the country organized similar plans and these eventually merged to form the Blue Shield Association.

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In 1929, the Ross-Loos medical group formed what is believed to be the first health maintenance organization in the United States, and provided prepaid medical care to Los Angeles County employees. During the 1930s, surgeon Dr. Sydney Garfield provided pre-paid care for the illnesses and injuries of employees of major public works construction projects in California, and later to employees of the Kaiser shipyards during World War II. After the war, as the number of employees in the shipyards dropped, the Permanente health plan was started, which opened to the public and attracted the support of unions, allowing it to grow over the next few years. This would eventually become the Kaiser Permanente health plan, which continues to operate today.

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In 1935, President Franklin D. Roosevelt pressed for Congress to pass the Social Security Act as part of the New Deal during the Great Depression. One of the law's major effects was establishing old-age benefits for people who have been employed - today's Society Security. However, the law also created a number of other benefits, including unemployment insurance, as well as aid to victims of industrial accidents, dependent mothers and children, the blind, and the physically handicapped. Later, amendments to the Social Security Act allowed for the two large Federal payment programs, Medicare and Medicaid.

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During the 1940s, commercial insurance carriers noted the growth of these hospital and physician "Blue" plan associations, and began to offer group health insurance. Conditions that supported the movement into this arena included providing insurance for large groups of employees, which spread the risk and helped address some of the moral hazard associated with health insurance. In addition, commercial carriers could adjust their rates based upon the age of the group members and their payment

experience, whereas the hospital association plans offered community rating, the same price for any insured person.

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Other factors contributed to the growth of commercial health insurance in the 1940s. Government wage controls during World War II limited the ability of employers to attract skilled workers. Health insurance was considered a benefit, not wages, and employers began to offer health insurance as a way of attracting and indirectly paying employees. In addition, the Internal Revenue Service offered favorable tax treatment to benefits provided by employers, making them free of payroll tax to the employer and free of income tax to the employee. Later, government rules prevented the cancellation of employer-sponsored health care contracts during a contract year, and permitted unions to negotiate health insurance benefits as part of wage negotiations.

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The Hospital Survey and Construction Act, commonly called the Hill-Burton Act, was passed during President Truman's administration in 1946. It stimulated construction of health care facilities and is the foundation of today's infrastructure for hospitals and other health care organizations. The Hill-Burton Act continues to authorize funding for public medical facilities and other nonprofit facilities, such as acute care general hospitals, specialty hospitals, nursing homes, public health centers, and rehabilitation facilities. To receive Hill-Burton funds, organizations must participate in the Medicare and Medicaid programs. In addition, the law imposes anti-discrimination rules on health care facilities that receive funds.

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Two amendments to the Social Security Act became law in 1965: Title 18, a social insurance plan known as Medicare, and Title 19, a social welfare plan known as Medicaid.

Medicare is a Federal insurance plan that reimburses providers and organizations directly for health care services. The main criteria for Medicare eligibility is that an individual be over the age of 65 or disabled. It is funded through the Federal Insurance Contributions Act or FICA, a payroll tax on an employee's earnings, which is matched by the employer.

Medicaid is a combined federal-state program that provides insurance for the poor using state and federal tax revenues, with administration at the state level. The main criteria for Medicaid eligibility is limited income and financial resources, or disability.

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Due to rising health care expenditures in the late 1960s, the Health Maintenance Organization, or HMO, Act of 1973 was passed into law in an attempt to lower rising health care costs. The law provided federal grants and loans to encourage the development of HMOs, and required employers with twenty-five or more employees that offered traditional health plans to also offer an HMO option.

HMOs were thought to lower costs by offering comprehensive hospital and physician services through a limited group of health care providers. The law allowed prepaid

health plan companies access to the employer-based insurance market, which led to the development of today's managed care organizations and techniques.

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Another important federal law affecting private insurance is ERISA, the Employee Retirement Income Security Act of 1974, which regulates employer self-funded health plans. It does not require a plan be established. However, it sets standards for plan administrators, establishes a grievance and appeals process for employees, and establishes the right to sue for benefits.

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The most major recent health care insurance legislation is the Patient Protection and Affordable Care Act - also known as the Affordable Care Act, the A-C-A, or Obamacare. The ACA was passed by Congress and signed into law by President Barack Obama on March 23, 2010. The program began enrolling patients in 2013.

The ACA legislation has two major goals. The first is to expand health insurance coverage, and the second is to improve the quality of care while reducing cost.

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There are a number of ways by which the ACA expands health insurance coverage.

The first is the subsidization of insurance for those who do not receive employer-provided health insurance. This is done for individuals and families who earn up to 400% of the U.S. poverty level. These individuals and families purchase coverage on health insurance exchanges that aim to simplify the selection of plans. A second form of subsidy is the expansion of Medicaid for states that choose to do so, with 90% of the cost picked up by the federal government. Medicaid eligibility is expanded for those who earn up to 133% of the U.S. poverty level. Insurance coverage is expanded in other ways by the ACA, such as allowing children up to age 26 to remain on their parents' health plans. The ACA also disallows the denial of insurance for pre-existing conditions or the dropping of insurance of those who become ill.

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The ACA also expands health insurance by providing subsidies for small businesses and by requiring larger companies with more than 50 employees to provide health insurance. It also closes the so-called Medicare "donut hole," resulting in reduced prescription prices for seniors.

In order to bring everyone into the health insurance pool, the ACA has an individual mandate that requires all who are eligible to either acquire health insurance or pay a fine.

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While there has been much political controversy over the ACA, it has resulted in a number of benefits to people using the health care system. Most importantly, the rate of those without health insurance in the U.S. has fallen from 18% to 11% since its inception.

There have been other benefits as well. There has been continued slowing of the growth of spending on health care, although the amount attributable to the ACA is unknown. Despite warnings from critics of the legislation, there has been no change in employment or reported hours worked, as some predicted. There has also been increased economic growth, especially in states expanding Medicaid, along with a reduction in the amount of uncompensated care provided by hospitals and other health care organizations.

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There are three types of state-licensed insurance organizations.

Commercial health insurers, also known as privately funded health plans, or simply insurance carriers, are most often owned by stockholders or stock companies. Aetna Insurance Company is one such example. Alternatively, these companies can be mutual insurance companies, which are owned by their policyholders.

BlueCross BlueShield is a nationwide association of thirty-nine independently operated companies. Originally, BlueCross BlueShield companies were not-for-profit organizations, but today some of them operate on a for-profit basis. Together, these companies are the nation's largest insurer, providing coverage for one in three Americans.

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Managed care organizations are the third type of state-licensed insurance organizations. These companies combine health insurance benefits with the actual delivery of health care services. They impose tight controls on costs and use of services, and some have their own doctors and facilities. The three main types of managed care organizations are: health maintenance organizations, or HMOs; preferred provider organizations, or PPOs; and point-of-service, or POS plans. Managed care organizations will be discussed in more detail in a later lecture.

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Self-funded plans are created by an employer, an employee organization, or a combination of the two. They operate under the ERISA rules. In this model, the employer assumes the risk of providing health care insurance to its workers and pays for their care directly. The employer may contract with a third-party administrator, which can be an insurance company, to oversee the plan and manage benefits. The employer may also purchase insurance that covers health care expenditures, or losses, that exceed a certain dollar figure.

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Publically-funded health care includes government programs, which are funded by income taxes and payroll taxes. These programs start in federal legislation and are voted into law by Congress to help specific population groups that meet eligibility requirements. Some, like Medicare, are run by the federal government, while others, like Medicaid, are federal-state partnerships.

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This slide shows some examples of publically funded health care programs. The Affordable Care Act or ACA we noted before. Medicare is for seniors and people with certain disabilities. Medicaid is for low-income individuals and families. The Children's Health Insurance Program is for children and pregnant women whose families earn too much to qualify for Medicaid but cannot afford private insurance. The Veterans Health Administration provides health care services for people who have served in the military. TRICARE is a health care program for active-duty service members and their families. The Indian Health Service serves American Indians and Alaska Natives.

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Note that in this discussion, the term government payors refers to programs whereby the government pays health care organizations, either directly or indirectly, to provide health care services, such as the state-run Medicaid programs. The government-operated delivery systems, such as the Veterans Health Administration, TRICARE, and the Indian Health Service are self- contained systems that operate facilities and have government-employed providers.

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The U.S. federal government has three key roles in health care. These include provider of health care services, payor for health care programs and services, and lawmaker.

As mentioned, the government directly provides health care services through programs such as the Veterans Health Administration, TRICARE, and the Indian Health Service. These systems include federally- and state-supported hospitals, clinics, health centers, doctors, and other services. The government also grants money for research projects that explore new models of providing health care.

In Medicare, Medicaid, TRICARE, and certain grants, the government provides funding for third-party services. One example is Medicare, whereby the government outsources the actual delivery of health care services for seniors to private organizations. Another example is that the government may contract with an insurance organization, such as BlueCross BlueShield, to handle claims processing on behalf of the government. Here, the commercial insurance organization acts as a third-party administrator.

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One objective of the government's third role, that of lawmaker, is to ensure fair competition. An example is the Sherman Anti-Trust Act of 1890. This law prohibits restraint of trade and monopolization, where one company takes over all of the business for a particular product or service, to the exclusion of other competitors.

In 1914, Congress passed the Clayton Act to close loopholes left by the Sherman Act. The Clayton Act addresses the pricing of goods and services, also known as "price-fixing", and targets monopolies and exclusive arrangements that restrict fair competition.

The second objective for the government in passing laws is to protect and serve the public. An excellent example in health care is the Federal Food, Drug, and Cosmetic Act, passed by Congress in 1938, which created the Food and Drug Administration, or FDA. The role of the FDA is to protect and promote public health.

In 1984, Congress passed the Hatch-Waxman Act, the full name of which is the Drug Price Competition and Patent Term Restoration Act. This law gives drug and device companies an incentive to develop new products by allowing them extra-long patent periods, to compensate them for the time they have to spend testing new products.

In 1990, the Americans with Disabilities Act was passed, which requires that people with disabilities have equal access to employment, transportation, state and local government services, most businesses and public places, and telephone service.

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This concludes lecture a of Financing Health Care, Part 1. In summary, the current system of health care payors in the U.S. developed as a result of historical and governmental influences. One of the main types of health insurance is the privately funded plan, which can be broken down into state-licensed insurers and self-funded, employer-sponsored plans. The other main type of health insurance comes from publically funded or government programs.

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The government has three roles in health care: to pass laws that ensure fair competition and protect the public; to provide health care services; and to pay for services.

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