Health Services In United States Essay, Research Paper

Health Services in United StatesThe historic payment system for reimbursing hospitals both by insurers and by Medicare has been Retrospective Cost Based Reimbursement(RCBR). This system of reimbursement encourages hospitals to over charge in order to cover the costs of the uninsured who utilize the hospital. Charges have continued to rise year after year eventually putting the employers at a point where they could no longer afford the payments. For physician reimbursements, both insurers and Medicare employed the Usual and Customary(U+C) approach to reimbursement. This practice, which averaged the charges for a procedure in a region, also encourages doctors to over-charge in order to raise the average amount paid to them for a procedure. These two systems, RCBR and U+C eventually started to suck too much money out of the insurers, employers, and the Medicare/Social Security trust fund so that interventions were deemed necessary. Perhaps the biggest intervention adopted by the private sector to reduce medical service costs was the trend toward businesses self-insuring. By doing so, they avoided state-mandated benefits that were required if they hired a third-party insurer. In addition, the money was now paid to claims as they arose rather than prospectively so income could be earned on this capital as it sat in the bank. Other intervention to reduce medical service costs mainly involved private insurers as it was difficult for small businesses to self-insure because of low-capitol. Underwriting was a typical practice of insurance companies; that is, excluding some employees from coverage if they have preexisting conditions or if they are employed in |high-riskX areas. Payment caps are were also employed by insurers as a way to save medical costs. This practice meant setting limits for the total amount paid for selected diagnoses. These interventions ultimately led to segmentation in the insurance market. A shift occurred in the way that insurers calculated premium charges. Community rating used to be the norm. It involves placing all beneficiaries into a large group and projecting their claims. Premiums were then spread across the entire group as were risks. However, as a result of the historical hospital and physician payments schemes, insurers shifted to experience rating. That is, a rating that bases a group+s premiums on its experienced cost. Therefore, by only including low-risk, low-cost individuals under coverage, premiums for those individuals may be minimized. This effect leaves small groups behind, paying much more in premiums. These interventions mentioned as well as increased experience-rating adopted by insurers and the subsequent phenomena of market segmentation have had effects on many levels of the health care system:Premiums for small employers have skyrocketed for two reasons. First, administrative costs for small employers are proportionally higher than those for larger firms(Congressional Research Service) and secondly, larger firms have more market clout and are so able to seal the contracts that provide lower premiums to their employees. Larger firms are also able to spread the risks of their insured employees across a larger beneficiary base with lots of capitol to absorb any abnormality in claims from one year to the next. Small firms don+t have this luxury and as a result their premiums have increased. As health care costs grew, many larger businesses opted to self-insure and take the risks of their employees rather than paying an insurance company to perform this role. These employers also avoided the state mandated benefits and could use capital not prospectively paid to earn interest. It was in the 1980 s, when employers were becoming increasingly concerned about soaring health care costs, commercial insurers were concerned about the future of traditional health insurance, and physicians were increasingly joining health plans to guarantee a steady flow of customers, that managed care really expand dramatically. As diagram 1 shows(see attachments), the number of people enrolled in HMO s in 1976 was 6 million and by 1991 had reached 38.6 million. The higher costs of medical care forced different groups into HMO s for different reasons. Doctors enrolled in HMO s gave up some autonomy but were guaranteed a steady flow of patients. The patients enrolled were guaranteed care for a fixed monthly premium at the expense of visiting only providers covered in their plan. The draining of the Social Security trust fund by traditional hospital RCBR method and physicians by U+C for Medicare was tackled by alternative payment mechanisms. The traditional U+C payment to doctors was replaced with the Resource Based Relative Value Scale(RBRVS) 1n 1992. This system of payment assigned a numerical value to every procedure performed in order to attempt to objectify what goes into a physician s service. In this way, the payments to physicians could be regulated and controlled. Hospitals, which were traditionally reimbursed under RCBR were paid by the Prospective Payment System(PPS) starting in 1983. Under this system, each episode of illness was associated with a fixed payment regardless of resources consumed, time spent, or expenses incurred. All illnesses were grouped into Diagnostic Related Groups(DRG) effectively cataloguing hospitalized patients according to fee payment. The ever-increasing costs associated with health care brought along many cost-saving interventions which have been mentioned. These interventions had effects at all levels of the health care industry but especially so in hospitals as they represent 38% of our nation s health expenditure. Hospital admissions declined sharply as the new payment schemes for hospitals were introduced in 1983. Since hospitals were being paid by a PPS system, the incentive was to get the patients out as soon as possible. Admitting patients is associated with high costs and hospitals opted for more outpatient care rather than admissions. This PPS payment structure also influenced the average length of stay. Hospitals were now encouraged financially to release patients as soon as possible since they were reimbursed the same amount regardless of the duration of the stay. Efficiency was now of paramount concern as a person sitting in a bed represented a cost that could be contained if the patient was released sooner than later. It is no surprise then that occupancy rates for hospitals have also declined since 1980.

This combination of reduced admissions and shorter length of stay per visit resulted in few people in hospitals at any given time. These trends present special problems for smaller, rural hospitals which have more difficulty gathering resources, staying technologically current, and maintaining financial strength. As a result, more and more smaller hospitals are closing, especially in these rural areas. The high level of unemployment in the early 1980 s along with stricter eligibility requirements for Medicaid led to a rise in the number of uninsured individuals in the U.S.(see diagram 2). Market segmentation beginning in the early 80 s also contributed to the number of uninsured as those with pre-existing conditions or high-risk jobs were denied coverage. Because of the highly competitive hospital market created by payment changes, the incentive to treat the uninsured is lost and these people are increasingly marginalized. No longer may hospitals subsidize the treatment of the uninsured by over-charging employers or insurance companies. Many cuts have proposed by the Republicans in Congress that aim to trim down the cost of health care. Medicare is at the root of many of these proposed policy changes. Among them are increases in co-payments made by beneficiaries, caps on payments to beneficiaries, a reduction in the amount paid to beneficiaries per episode of illness, a holding of the rates of increase for hospitals and doctors so that if services increase, payments decrease, and letting the market naturally move people into HMOs. These proposed policy changes are likely to effect hospitals in many ways, some of which are already being seen. It is likely that hospital admissions will continue to decline as hospitals have no incentive to admit. Payments are the same to hospitals whether the treat outpatient or they admit the patient, so to save money the natural tendency is to treat with ambulatory or outpatient care. Even more incentive is present for hospitals not to admit a patient as the amount paid to them will decrease as they increase services. Incentive to not treat+ is what it may be called. For those that are admitted to hospitals, we will continue to see a reduction in the number of days each patient stays in the hospital. The motivation for the hospital to release the patient persists because of the payment schemes in place. For the patient who is paying a higher co-payment, the incentive is also to leave the hospital as soon as they feel well enough…and sometimes before! What we are likely to see are increasing numbers of rural hospital closures as they are unable to survive the drop in hospital visits and stays. Empty beds mean administrative costs for the hospital that need to be defrayed by treating people. If there is nobody to treat, the hospital must inevitably shut down. As people continue to move into HMO s to receive some sort of coverage, hospitals will perhaps see an increase in the number of visitors at hospitals but they will be required to receive prior approval for most procedures and the amount paid to the hospitals will remain the same regardless of the number of procedures so the incentive to treat more is lost. As Medicare cuts continue to prevail, it is likely that more and more beneficiaries of Medicare will be drawn into HMO s. Just as this has led to increased market segmentation in the private-insurance community so would it lead to the same dynamic in the Medicare community. Those hospitals or physicians that sign contracts with HMO s will be securing their patient-base while the HMO will be cornering more of the hospital/physician market. For those who are not enrolled in HMO s, their costs will not be controlled. Higher fees will be the likely result. Since the Medicare reform proposals pay less per episode of illness, the patient will be responsible for more of this increased amount. The amount of Medigap payments for Medicare beneficiaries is also likely to go up as a result of the current Medicare reform proposals. Medicare will pay less per episode of illness. If we assume that the charge per episode of illness will not come down, then the amount that must come out of the pocket of the beneficiary must increase. This increase will be a direct result of the cuts to the Medicare program. Long-term care in the United States has received much attention in recent years as the baby-boomers soon will be the population requiring this type of care. For those seeking long-term care there are several options available with different payments sources for each. They are briefly outlined here:Nursing Homes: nursing home care may be provided in different settings with differing payment options for each. They are consumer payment-this type of care may include anything qualifying as daily care for an elderly or mentally-ill patient requiring long-term care. There is generally a daily charge rate for the custodial care. Mediacaid covers custodial and general care once personal funds are depleted. Medicare covers skilled nursing and skilled therapies following hospitalization This coverage is limited to 100 days maximum per episode. Home/Community-Based Care: this type of care consists of skilled nursing care and therapies, homemaker/home health aid care, high technology home therapy, and durable medical equipment. Consumer bought care may include personal care, including the aforementioned home health aids and homemakers and chore services. Also, any RN time spent beyond that authorized would be covered by the patient. Medicaid covers personal care and assistance for eligible frail elderly or disabled individuals. Medicare covers skilled nursing, physical or speech therapy. Housing/Retirement Community: this is an enhanced service package and often includes more supportive or custodial care. A combination of both Medicare and Medicaid may be used to pay for this type of service. One organized method to do just this is the Program of All-Inclusive Care for the Elderly(PACE). The idea is that for qualified individuals, PACE merges Medicaid and Medicare funding into an integrated system that enables a care-manager to allocate resources by need. PACE must be seen for what it is, care for acute and chronic conditions within a long-term care package. Diagram 1 Diagram 2Source: U.S. Bureau of the Census, Unpublished Current Population Survey Data, Health Insurance Coverage Status by State, Table Hi-4.