Health Insurance & Payment

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Learning Outcomes

1. Identify the health consequences experienced by the uninsured.
2. Review the types of health insurance as it relates to access to care and health care coverage.
3. Discuss the No Surprises Act and why it is important.
4. Describe value-based purchasing, examples from practice and the RNCM role.

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The Health Consequences of Being Uninsured

Why Health Insurance Matters

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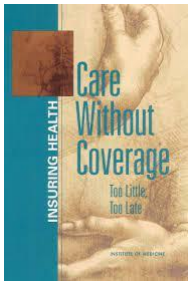
2002 IOM Groundbreaking Report:



"Care without Coverage: Too Little, Too Late"

- No health insurance = additional deaths in adults ages 25 and 64
- Job loss = loss of health coverage
- Rising health insurance premiums = unaffordable

- 2010 ACA implemented laws to reduce the growth of uninsured Americans
  - No longer deny or charge higher premiums to people with pre-existing conditions
  - Established the Health Insurance Exchange also called the Health Insurance Marketplace

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Uninsured people receive less medical care & less timely care:

More likely to:

- Receive an initial diagnosis in the advanced stages of a disease
- Die or suffer permanent impairment after an accident or sudden onset condition
- Live with a chronic condition that could be managed if diagnosed

Many uninsured people avoid seeking medical care unless they are faced with an emergency or delay care until their symptoms become intolerable

Uninsured people have worse health outcomes:

- Sicker and more likely to die prematurely
- Death risk is 25% or higher for people with certain chronic conditions

Access to coverage improves health.

Access to coverage saves lives.

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Lack of Health Insurance is a fiscal burden for uninsured people & their families:

- Do not benefit from discounted medical pricing
- Medical debt is a significant contributing factor in bankruptcies

Safety net care helps improve access, but the improvement is less than what insurance achieves

Health Insurance Exchange: Healthcare.gov https://www.healthcare.gov/

- Affordable Care Act
  - Established "minimum essential coverage" insurance standard
- Health Insurance Exchange (aka Marketplace)
  - An Exchange is "***a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.***" – The Commonwealth Fund
- Eligibility:
  - Live in U.S., be a U.S. citizen or national, cannot be in prison
- Open Enrollment:
  - Apply online, by phone, paper application

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Types of Health Insurance

An Overview

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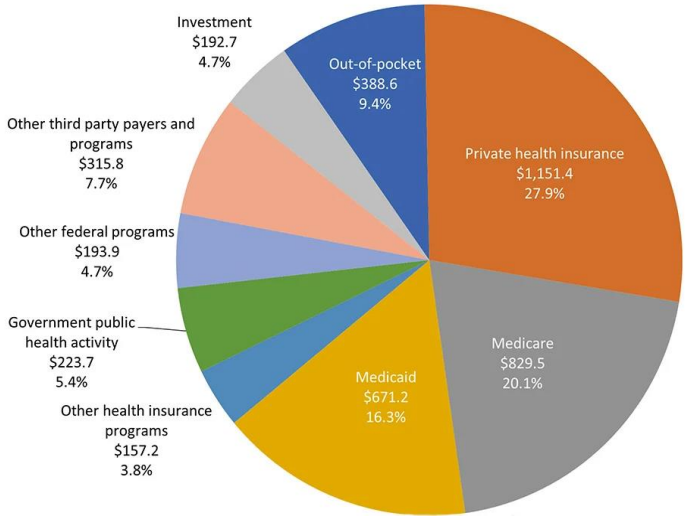
Who pays the bill?
2020 health care spending decomposed by source of funds



Source: Trends in Healthcare Spending (American Medical Assoc.)
https://www.ama-assn.org/about/research/trends-health-care-spending

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Commercial or Private

- Commercial health insurance is run by private companies instead of the government.
  - 900+ - each state has 5 or so companies that are the major providers
- You can get group commercial health insurance plans through your employer, or you can purchase non-group coverage on your own.
- Commercial health insurance is a broad term that includes several different types of insurance plans.

Practice Tip: Identify the major insurance plans that interface with your healthcare organization and population served. Become familiar with these plans.

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Government Insurance Plans (Federally Funded Public Programs)

A program run by U.S. federal, state, or local governments in which people have some or all of their healthcare costs paid for by the government

- The two main types of public health insurance: Medicare Medicaid
- Established in 1965, when President Johnson signed into law the Social Security Act,
- Programs designed to provide health coverage and financial security:
  - Medicare provided for older Americans
  - Medicaid provided for low-income Americans

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Medicare https://www.cms.gov/

- CMS provides administrative oversight estimated 60 million individuals (18.4% of the U.S. population)
- Benefits those:
  - Age 65 or older
  - ESRD and ALS
  - Under 65 who have received SSDO for at least 2 years (disabilities)
- Coverage:
  - Part A: hospitalizations, skilled nursing care, home/custodial care, hospice
  - Part B: physician services, outpatient services, ambulance transport, clinical research, mental health
  - Part D: Prescription drugs
  - Part C: Medicare Advantage Option (Medicare Choice, Managed Medicare)

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Medicaid https://www.medicaid.gov/

- CMS provides administrative oversight to 1 in 5 Americans (75 million people)
- Joint Federal-State program that finances
  - Primary and acute medical services
  - Long term services and supports – principal sources of LTC for Americans
- Supports a diverse low-income population
  - Children
  - Pregnant women
  - Adults
  - Individual with disabilities
  - People aged 65 or older
- Children's Health Insurance Program (CHIP)
  - Children and Pregnant Women in families that have an annual income above Medicaid eligibility but no health insurance

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Indian Health Services

https://www.healthcare.gov/american-indians-alaska-natives/

- HHS agency providing comprehensive health service delivery to 2.2 million of the nation's estimated 3.7 million American Indian & Alaska Natives
  - Members of 567 federally recognized AI/AN Tribes and their descendants are eligible
- IHS responsibility to uphold the Federal Government's obligation:
  - to promote the health of Indian people
  - honor their cultures
  - protect the inherent sovereign rights of Tribes
- IHS is a service provider not a health insurance
  - IHS owned facilities, Tribal Health Programs, Urban Health Program, Purchased Care
- Tribal members still need health insurance to pay for care
  - Health Insurance Marketplace including Medicaid and Medicare

Military Health Care Services

- Military service members, veterans and their dependents
- Department of Defense
  - TRICARE – 9 million
- Department of Veterans Affairs
  - VA Care – 3 million

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Military Health System

- The Department of Defense provides administrative oversight for America's 1.4 million active duty and 331,000 reserve personnel
  - Provide care through military hospitals and clinics
- TRICARE - The Uniformed Services Insurance Plan
  - Active-duty service members, active-duty family members, National Guard and Reserve members and their family members, retirees and retiree family members, survivors and certain former spouses worldwide
  - Multiple plan options available with eligibility determined by the Service Personnel Office
  - In general, Active Duty do not pay out of pocket expenses other co-pays determined by your eligibility plan
  - https://www.tricare.mil/

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VA Health Care https://www.usa.gov/veteran-health

- Dept Veterans Affairs operates the Veterans Health Administration serving 9 million enrolled veterans/year
  - Largest integrated health care system: 1298 health care facilities – 171 medical centers, 1113 VHA outpatient clinics
  - Benefits for those who served in the active military, naval or air service and did not receive a dishonorable discharge.
- VA Health Care
  - Veterans returning from combat operations can enroll within 5 years of return
  - If combat veteran doesn't apply within 5 years or never took part in combat operations, different high-priority group
  - Prioritized eligibility for VA care determines how much care a veteran is eligible for and cost in terms of copayments
  - Additional health insurance may be needed and is available through the Health Insurance Marketplace including Medicaid and Medicare
  - https://www.va.gov/health-care/about-va-health-benefits/va-health-care-and-other-insurance/

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VA Health Care (cont.)

- CHAMPVA
  - Civilian Health & Medical Program of the VA
  - Benefits program in which the VA shares the care services and supplies
  - Eligible beneficiaries: spouse or surviving spouse, or child of, a veteran with disabilities or who has died
  - Similar services to TRICARE however CHAMPVA is a VA program and TRICARE is a DoD regionally managed healthcare program
  - Military retiree, or spouse of a Veteran killed in action will always be a TRICARE beneficiary – cannot choose between the two programs
  - https://www.benefits.gov/benefit/318

VA Health Care (cont.)

Veterans Community Care Program
- https://www.va.gov/communitycare/

- A program established as part of the 2018 Mission Act that allows eligible veterans to be receive care in their local community
  - More than 1/3 VA-enrolled veterans use CCP
- VA provides care to Veterans through community providers when VA cannot provide the care needed.
  - Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans
- Many Challenges
  - Community Providers to identify they are serving a veteran and their unique needs
  - Have You Ever Served? American Academy of Nursing https://www.haveyoueverserved.com/

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No Surprises Act

- New federal protections against surprise medical bills (2022)
- Surprise bills occur when consumers inadvertently receive care from out-of-network hospitals or providers they did not choose
  - 1:5 emergency room visits
  - Between 9-16% of in-network hospitalizations for non-emergency care include surprise bills
- Financial burdens on consumers
  - health plans deny out-of-network claims or apply higher out-of-network cost sharing
  - ‘”balance billing” from out-of-network providers who have not contracted to accept discounted payment rates
- Federal Government estimates NSA will apply to >10 million out-of-network surprise medical bills/year

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NSA protects consumers by:

- Requiring private health plans to cover these out-of-network claims and apply in-network cost sharing
- Prohibits hospitals and providers from billing patients more than in-network costs
- Establishes a process for determining the payment amount
  - negotiations between plans and provider
  - independent dispute resolution process
- CMS provides detailed information for providers and consumers
  - https://www.cms.gov/nosurprises

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Value Based Purchasing

How Health Care Payment is Changing

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What is Value-Based Purchasing

"Linking provider payments to improved performance by healthcare providers. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best performing providers." – Healthcare.gov

VBP initiatives are geared to help patients have better "user" experiences and improved clinical outcomes

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Historically, U.S. Health Care Payment

- Fee for Service Compensation
  - Reimbursement based on volume of services regardless of patient outcomes
- HMOs Introduced in the 1970s
  - Included more preventive care
  - Practice requirements were defined for participating networks
  - Capitated payment models
- HMO Models 1980s & 90s
  - "Utilization Review based on Medical Necessity"
  - Viewed negatively by the public "rationing" care
  - Often resulted in lower health outcomes
- 1990s to passage of ACA in 2010
  - Multiple VBP programs demonstrated

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ACA Success

- Significant reforms to improve quality reigning in costs
- CMS Leader in VBP
  - 2015 Medicare Access and CHIP Reauthorization Act (MARCA)
- Today DHHS integrating most provider payments to reimbursement formulas based on performance and quality
- Tools for implementing VBP initiative involves a "carrot & stick" approach to improving performance
  - Ex: Carrot = Bonus payments
  - Stick = less financial reimbursements
  - Some programs use both approaches

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Public Programs

CMS Sponsored VBP Programs

- Hospital Value-Based Purchasing Program
- End-Stage Renal Disease Quality Incentive Program
- Hospital Readmission Reduction Program Value Modifier Program
  - (also called the Physician Value-Based Modifier or PVBM)
- Hospital-Acquired Conditions Reduction Program
- Skilled Nursing Facility Value-Based Program
- Home Health Value-Based Program

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VNP and Private Programs

- Driven by employers, labor unions, private group purchases
- Developing quality improvement programs, report cards, other measurements tools
- Purchasing based on quality not just cost and benefits
- AHRQ provides a summary of several private sector demonstration program
- https://www.ahrq.gov/patient-safety/quality-measures/21st-century/private-sector.html

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VBP and RNCM Practice

Calls on RN Case Managers, Care Managers, Care Coordinators to implement targeted interventions to improve clinical & financial outcomes

- Coordinate health strategies for targeted populations
- Pay for Performance length of stay parameters
- Readmission prevention
- Transitions of care
- Complex condition management
- Self-management support

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Challenges

Work continues to move forward in the areas of:

- Benchmarking
- Measurement Consistency
- Fragmentation
- Statistical Validity
- Comparative Effectiveness

RNCMs will have an important perspective on what is and is not working

Your input will be important

in optimizing the clinical and financial impact of VBP programs

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RNCM Advocacy & Care Coordination

- Assessment of Insurance Coverage
  - Payment sources
  - Benefits covered
  - Eligibility for other services & resources
- Patient Education
  - Open Enrollment Periods
    - Market Place - healthcare.gov - https://www.healthcare.gov/
    - Medicare - mymedicare.gov - https://www.medicare.gov/
  - How to Read a Bill
  - Updates on health policy changes impacting care (e.g., No Surprises Act)
- Practice Support Partners
  - Coding/billing
  - Insurance assistors
  - Payer contacts

Next Steps

- Watch the videos that accompany this lecture
- Review the posted Resources. Download any you would like to keep.
- Complete the Practice Development Activity
- Take the Test Your Knowledge Self-Assessment Quiz. These are a set of tutorial quizzes from KFF
- When you're ready move onto the next topic

- Questions? Let me know:
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