

This is a sample of the instructor materials for Robert H. Lee, *Economics for Healthcare Managers*, third edition.

The complete instructor materials include the following:

- Test bank
- [Course lesson plans](#) (167 pages) and course project rubric
- Instructor's manual (102 pages) that includes answers to the book's discussion questions
- PowerPoint slides for each chapter

This sample includes the following materials:

- The pages from the course lesson plans for Chapter 3
- The pages from the instructor's manual pertaining to Chapter 3
- The PowerPoint slides for Chapter 3

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to hapbooks@ache.org and include the following information in your message:

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- Course level (graduate, undergraduate, or continuing education) and expected enrollment
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- A contact name and phone number/e-mail address we can use to verify your employment as an instructor

You will receive an e-mail containing access information after we have verified your instructor status. Thank you for your interest in this text and the accompanying instructor resources.

Digital and Alternative Formats

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Unit 2: An Overview of the Healthcare Financing System

Unit Learning Objectives

- CO 1: Examine the overall economic and financial challenges of the US healthcare system
 - Use standard health insurance terminology
 - Identify major trends in health insurance
 - Describe why health insurance is common
 - Describe the major problems faced by the current insurance system
 - Locate current information about health insurance

Readings

Read: *Economics for Healthcare Managers, 3e* Chapter 3

Unit Activities

Content Outline: Session 1 An Overview of the Healthcare Financing System

Unit Objectives:

- Use standard health insurance terminology
- Describe why health insurance is common
- Describe the major problems faced by the current insurance system

15 – 20
min

Topics:

- Review the objectives for Chapter 3
- Who pays for healthcare? (Slides 3–4, 6)
 - Consumers: directly, via out-of-pocket
 - Consumers: indirectly, via insurance premiums, wage reductions, taxes
 - **[not on slides]** Review *copayment, deductibles, cost sharing*
 - **[not on slides]** Consider discussing the topic of “Boom and Bust in Home Care” in relation to Medicare as shown on pp. 39–40
 - **[not on slides]** Consider discussing people who are uninsured
- Reasons for having insurance (Slides 7–11):
 - Illustrate with examples on slides 8–10
 - Pools the risks of healthcare costs

Instructor
PowerPoint
slides:
Chapter 3:
Slides 1 –
30
(selected)

- Affects how and how much consumers pay and providers get
- Affects incentives
- Consider discussing *underwriting* [**not on slides**], *moral hazard*, and *adverse selection* [out of slide order on Slides 25–28]
- **Note:** View slides out of order to discuss the flow of funds in Medicare (Slide 5)

In-Class Discussion

- Based on economics only, would you advise anyone to stay uninsured? Why or why not? (In your answer, you could imagine the ACA had not been passed, or you could refer to its penalties for the uninsured.) 15 – 20 min
- What is your personal view of the ACA? How do you think it has affected healthcare economics in the United States?
- How does your insurance plan affect your use of healthcare services? How is the use of healthcare services different for people with different types of insurance plans?

In-Class Activity

Activity: Quiz

15 – 20
min

Take students through a short, ungraded multiple-choice quiz to check their understanding of concepts covered in this class session. Track student responses to the quiz questions using the method of your choice (e.g., show of hands, use of clickers, or help from volunteer note takers).

To generate student interest and participation, remind them that this is an ungraded session (no penalty for wrong answers).

1. The main function of insurance is to
 - a. make healthcare free.
 - b. reduce total spending on healthcare.
 - *c. pool the risks of healthcare costs.
 - d. all of the above

2. Direct consumer spending on healthcare
 - a. is a very large market.

- b. is a very small proportion of total healthcare spending.
- c. is often called out-of-pocket spending.
- *d. all of the above
3. Which of the following statements is true?
- a. Out-of-pocket spending has been rising as a share of the total.
- b. The uninsured tend to have above-average incomes.
- c. The share of Americans without health insurance fell between 1987 and 2006.
- *d. The uninsured often have problems accessing appropriate care.
4. A surgeon charges \$5,000 for a procedure. His contract with your insurer sets an allowed fee of 80 percent of charges. You are responsible for 25 percent of the allowed fee. How much do you pay?
- *a. You pay \$1,000.
- b. You pay \$1,250.
- c. You pay \$2,250.
- d. You pay \$3,000.

Follow-up Activity: Quiz Discussion

Discuss questions students had difficulty with, or review material if a majority of the class returned incorrect answers on the same questions.

Content Outline: Session 2 An Overview of the Healthcare Financing System

Unit Objectives:

- Use standard health insurance terminology
- Identify major trends in health insurance
- Describe the major problems faced by the current insurance system
- Locate current information about health insurance

15 – 20
min

Topics:

- Types of insurance:
 - Fee-for-service pays a share (Slides 12–13); ask

Instructor
PowerPoint
slides:
Chapter 3:

- “What problems does this create?”
- Managed care (Slide 14): reaction to the shortcomings of FFS and to variability of care
 - PPOs (Slide 15): most common type of managed care
 - **[not on slides]** Consider discussing HMOs: *group model HMOs* and *capitation, staff model HMOs, independent practice association HMOs (IPA HMOs)*
 - **[not on slides]** Consider discussing POS plans (“a combination of PPO and IPA” [p. 47])
 - **[not on slides]** Consider discussing *high-deductible plans (HD plans)* a.k.a. *consumer-directed health plans*
- Prices and insurance (Slides 16–21)
 - High and variable in the United States due to high private prices
 - Discuss: How would you feel if you paid \$20,000 for an appendectomy? (Slide 21); further payment discussion questions on Slides 23–24 and 29–30
 - **[not on slides]** Give an overview of “recent developments in Medicare, Medicaid, and ACA marketplace plans” (p. 48)
 - Medicare: “launched a series of demonstration projects and major changes in Medicare Advantage” that “appears to have improved outcomes for Medicare Advantage customers and has increased enrollment significantly” (p. 48–49)
 - Medicaid: “creation of managed care plans for beneficiaries who are also eligible for Medicare” (p. 49)
 - ACA: “plans are new, but most have used narrow provider networks to keep premiums down” (p. 49)
- Slides 12 – 30
(selected)

In-Class Discussion

- Read and discuss Case 3.2: “Group Health Cooperative’s Patient-Centered Medical Home” (pp. 49–50). 15 – 20 min
- Which of the “recent developments” described in the lecture (for example, the ACA, Medicaid, or Medicare) seems like it will most greatly affect healthcare economics? Why?

In-Class Activity

Activity: Case 3.1, “Federal Employees Health Benefits Program as the Model for Marketplace Plans” 20 – 30 min

Break students into small groups of three or four, and instruct them

to review Case 3.1: “Federal Employees Health Benefits Program as the Model for Marketplace Plans” (pp. 46–47).

- Have the students discuss the discussion questions (or as many as time will allow) on p. 47.

Follow-up Activity: Continued Case Analysis

Reorganize students into completely new groups and assign each group just one or two questions from the case. Have them share their previous groups’ opinions about these questions and perhaps find a new approach. Defend this approach using an article from a healthcare trade journal or online industry website.

Note: For online courses, have students complete this activity and its follow-up using the available technology of your choice (e.g., through a discussion board or in a video or text chat).

Content Outline: Session 3 An Overview of the Healthcare Financing System

Unit Objectives:

- Use standard health insurance terminology
- Identify major trends in health insurance
- Describe the major problems faced by the current insurance system

15 – 20
min

Topics:

- Payment systems matter—because they affect incentives and care (Slides 31–49): (**Note:** This bullet and its sub-bullets serve as an overview; some of this material is covered again later in this lecture.)
 - How providers get paid and how much: physicians by the hour; providers by the hour, defined procedure, case rate, or capitation
 - Importance of potential to modify payments
 - Rationale for supply curves sloping up
 - How patients pay and how much: fees, insurance premiums, and general taxes; difference between high and low copays
- Payment systems (Slides 50–57)
- Standards of simplicity, transparency, efficiency, consistency
- Piece rates common in healthcare only (includes FFS and case rates)
- Discuss pros and cons of *fee-for-service plans (FFS)*, *case rates*, *capitation*, *salary*; define each
- Characteristics of future payment systems:
 - Blend a variety of financial incentives

Instructor
PowerPoint
slides:

Chapter 3:
Slides 31 –
66

- Keep financial incentives
- Rely more on non-financial incentives
- Chapter 3 conclusions (Slides 58–66)
 - Consumers pay for healthcare directly and indirectly
 - Insurance is common, with individual plans on the rise
 - Incentives and outcomes depend on how and how much providers get paid/how and how much patients pay
 - Problems with incentives: Designing incentives is hard
 - Financing is important

In-Class Discussion

- Discuss Exercise 3.3 in Chapter 3: “‘The United States is the land of the overinsured, the underinsured, and the uninsured.’ What do you think these concepts mean? Why might this comment be true?” (p. 53) 15 – 20 min
- **Note:** Ask the next three questions in the order they are presented here.
- Physicians deal with hundreds of insurance plans, each using different billing codes and allowed fees. How would physicians’ costs change if every insurer had to use Medicare billing codes and electronic billing formats?
- How would physicians’ revenues change if every insurer paid Medicare rates (which are often lower than commercial insurance rates?)
- Would you recommend that the United States require all insurers to use Medicare rates, billing codes, and formats?

In-Class Activity

Activity: Course Project Preparation: Selecting a Topic

15 – 20
min

Allow students to work independently (or in pairs or small groups) and investigate the possible research prompts from which they may choose for their course-long research paper.

- The list of research project topics is provided in the “Outside of Class Work” section for this week.

Follow-up Activity: Selecting a Topic Discussion

As an entire class (either in person or on a discussion board), share ideas about the possible topics from which to choose when completing this paper, along with some of the research strategies that might be helpful for the assignment.

Outside of Class Work (Homework)

Individual Work: Chapter 3 Exercises

In Microsoft Word and Excel documents, complete the exercises at the end of Chapter 3 (with the exception of Exercise 3.3, which was discussed in Session 3).

3.1 Why is health insurance necessary?

3.2 Explain how adverse selection and moral hazard are different, and give an example of each.

3.4 Private health insurers have been slow to develop and adopt proven cost containment innovations (e.g., case rates or disease management programs). Why do you think this is the case?

3.5 A radiology firm charges \$2,000 per exam. Uninsured patients are expected to pay list price. How much do they pay?

3.6 A radiology firm charges \$2,000 per exam. An insurer's allowed fee is 80 percent of charges. Its beneficiaries pay 25 percent of the allowed fee. How much does the insurer pay? How much does the beneficiary pay?

3.7 If the radiology firm raised its charge to \$3,000, how much would the insurer pay? How much would the beneficiary pay?

3.8 A surgeon charges \$2,400 for hernia surgery. He contracts with an insurer that allows a fee of \$800. Patients pay 20 percent of the allowed fee. How much does the insurer pay? How much does the patient pay?

3.9 You have incurred a medical bill of \$10,000. Your plan has a deductible of \$1,000 and coinsurance of 20 percent. How much of this bill will you have to pay directly?

3.10 Why do employers provide health insurance coverage to their employees?

3.11 Your firm offers only a PPO with a large deductible, high coinsurance, and a limited network. You pay \$400 per month for single coverage. Some of your employees have been urging you to offer a more generous plan. Who would you expect to choose the more generous plan and pay any extra premium?

3.12 What are the fundamental differences between HMO and PPO plans?

3.13 Suppose that your employer offered you \$4,000 in cash instead of health insurance coverage. Health insurance is excluded from state income taxes and federal income taxes. (To keep the problem simple, we will ignore Social Security and Medicare taxes.) The cash would be subject to state income taxes (8 percent) and federal income taxes (28 percent). How much would your after-tax income go up if you took the cash rather than the insurance?

3.14 How different would this calculation look for a worker who earned \$500,000 and lived in Vermont? This worker would face a state income tax rate of 9.5 percent and a federal income tax rate of 35 percent.

- CO 1: Examine the overall economic and financial challenges of the US healthcare system

Course Project: Research Paper Topic Selection

Review the list of topics below, and select one for your course-long research paper. Then, write an informal, one-page description of the topic you have chosen. This description should include the preliminary approach you plan to take in conducting research and answering the question(s) in the prompt.

Select your topic from the following list.

1. Defend the case for not-for-profit healthcare organizations.
2. Defend the case for for-profit healthcare organizations.
3. Perform profit maximization analysis for a real-world healthcare organization.
4. Analyze the different techniques for forecasting sales. Make a five-year sales forecast for a real-world healthcare organization.
5. Analyze the pricing decisions for a real-world healthcare organization.
6. Discuss the principal–agent problem in a real-world healthcare organization. Make a recommendation that might resolve the problem. Defend your recommendation using current scholarly literature.
7. Design an incentive pay system for the following that minimizes the asymmetrical problem:
 - Physicians
 - Administrators
 - Staff
 - Nurses
8. Conduct an economic analysis of a relevant intervention for a real-world healthcare organization using the four types of analyses. Come up with a recommendation.
9. Discuss the economic reasons for market failure in your industry. Give real-world examples of each, other than those used in the text.
10. Describe the types of government intervention present in the healthcare industry. How will the Affordable Care Act change this? Describe the potential economic benefits and disadvantages of each type of intervention.
11. Do an in-depth study of supply and demand for a real-world healthcare organization. Be sure to include:

- Factors of demand
 - Factors of supply
 - Shifts in demand, real and potential
 - Shifts in supply, real and potential
 - Expected changes in supply and demand in the next five years
12. Research and describe five situations in which asymmetric information resulted in opportunistic activity. Be sure to find examples of different reasons for asymmetric information. For each, provide a solution.
 13. Conduct an analysis of elasticity for five different types of prescription drugs. Be sure to analyze all types of elasticity.
 14. Perform an analysis of market power for a healthcare organization in your area.
 15. Choose a common intervention, and conduct an economic analysis using different techniques for that intervention. Be sure to use all four methods and make a final recommendation.
 16. Analyze the economic effects the Affordable Care Act will have on the healthcare industry. Describe the successful healthcare organization under the ACA.
 17. Use behavioral economics to solve a common American health problem such as alcoholism, obesity, or cancer.

Save the returned copy of your work (with instructor comments/feedback) to your course project portfolio.

- CO 1: Examine the overall economic and financial challenges of the US healthcare system

Discussion Board Questions:

- As a healthcare manager, what would you do if your employers planned to raise healthcare costs for the majority of their customers by more than 25 percent? What action would you like to take in such a scenario, and how would such actions be constrained by your position within the organization?
 - CO 1: Examine the overall economic and financial challenges of the US healthcare system
- Conduct research to find a news story that illustrates the concept of *moral hazard* or *adverse selection* in the healthcare context. Briefly discuss the story's main points, and explain how it converges with or deviates from the textbook's presentation of these concepts.

- CO 1: Examine the overall economic and financial challenges of the US healthcare system

Chapter 3: An Overview of the Healthcare Financing System

Key Concepts

- Consumers pay for most medical care indirectly, through taxes and insurance premiums.
- Direct payments for healthcare are often called out-of-pocket payments.
- Insurance pools the risks of high healthcare costs.
- Moral hazard and adverse selection complicate risk pooling.
- About 85 percent of the US population has medical insurance.
- Most consumers obtain coverage through an employer- or government-sponsored plan.
- Receiving insurance as a benefit of employment has significant tax benefits.
- Managed care has largely replaced traditional insurance.
- Managed care plans differ widely.

Solved Exercises

- 3.1. Why is health insurance necessary? *Health insurance is necessary because healthcare costs are so skewed. Most people spend relatively little, but an unfortunate few spend huge amounts. People often want insurance to protect them from large, uncommon losses.*
- 3.2. Explain how adverse selection and moral hazard are different, and give an example of each. *Adverse selection involves individuals with different risks sorting themselves into different insurance pools. For example, young, healthy workers who do not have a personal physician are more likely to join an HMO than are older or less healthy workers who have an established relationship with a physician. So, average spending will be lower for the HMO group, even if the HMO does nothing to reduce costs. Moral hazard involves purchasing a product or purchasing more of a product because it is covered by insurance (and the consumer bears only part of the cost). For example, a consumer with coverage for flu shots is more likely to get them than a consumer without coverage.*
- 3.3. “The United States is the land of the overinsured, the underinsured, and the uninsured.” What do you think that these concepts mean? Why might this comment be true? *About 48 million Americans lacked health insurance as of 2014, so the third part of the comment is clear. Many Americans with insurance are overinsured because they have coverage for “uninsurable” expenses. A small expense that occurs with high probability, such as routine dental examinations or replacement of eyeglasses, costs much more to buy via insurance than it does directly and is said to be uninsurable. Insurance benefits are just ways of reducing taxes. These same consumers may have very limited coverage for uncommon, expensive services (which are precisely the sorts of expenses that insurance should cover). Consumers like these are underinsured, because they are at risk for catastrophic expenses. These first two comments are true largely because the tax code gives very large subsidies to high-income employees who get health insurance benefits at work and no subsidies to low-income employees who do not. Why so many people are left*

at risk for catastrophic expenses is not clear.

- 3.4. Private health insurers have been slow to develop and adopt proven cost containment innovations (e.g., case rates or disease management programs). Why do you think that is the case? *Most have such a small market share that it is difficult to get providers to accept unfamiliar payment systems. In addition, a company that spent its resources to develop a successful program would find that other companies that did not would quickly copy it. The payoff to innovation is apt to be small. In addition, until recently many companies lacked the analytic capacity to assess cost containment strategies.*
- 3.5. A radiology firm charges \$2,000 per exam. Uninsured patients are expected to pay list price. How much do they pay? *Usually they will pay \$2,000.*
- 3.6. A radiology firm charges \$2,000 per exam. An insurer's allowed fee is 80 percent of charges. Its beneficiaries pay 25 percent of the allowed fee. How much does the insurer pay? How much does the beneficiary pay? *The allowed fee is \$1,600 = 0.8*\$2,000. Of this beneficiaries pay \$400 and the insurer pays \$1,200.*
- 3.7. If the radiology firm raised its charge to \$3,000, how much would the insurer pay? How much would the beneficiary pay? *The allowed fee would rise \$2,400 = 0.8 × \$3,000. Of this, beneficiaries pay \$600 and the insurer pays \$1,800.*
- 3.8. A surgeon charges \$2,400 for hernia surgery. He contracts with an insurer that allows a fee of \$800. Patients pay 20 percent of the allowed fee. How much does the insurer pay? How much does the patient pay? *The allowed fee is \$800, of which patients pay \$160 and the insurer pays \$640.*
- 3.9. You have incurred a medical bill of \$10,000. Your plan has a deductible of \$1,000 and coinsurance of 20 percent. How much of this bill will you have to pay directly? *You will pay \$2,800. The deductible is \$1,000 and the coinsurance is \$1,800 = 0.2 × (\$10,000 - \$1,000).*
- 3.10. Why do employers provide health insurance coverage to their employees? *Employees want insurance coverage, so employers offer it to attract and retain them.*
- 3.11. Your practice offers only a PPO with a large deductible, high coinsurance, and a limited network. You pay \$400 per month for single coverage. Some of your employees have been urging you to offer a more generous plan. Who would you expect to choose the more generous plan and pay any extra premium? *Such a plan would be most attractive to those who anticipate high expenditures, primarily those with pre-existing conditions.*
- 3.12. What are the fundamental differences between HMO and PPO plans? *PPO plans usually have larger provider networks and less restrictive coverage of out-of-network providers.*
- 3.13. Suppose that your employer offered you \$4,000 in cash instead of health insurance coverage. Health insurance is excluded from state and federal income taxes. (To keep the problem simple we will ignore Social Security and Medicare wage taxes.) The cash would be subject to state income taxes (8 percent) and federal income taxes (28 percent). How much would your after-tax income go up if you took the cash rather than the insurance?

P = Pretax Amount	\$4,000		
F = Federal income tax = $-0.28 \cdot P$	-\$1,120		
S = State income tax $\text{\$} = -0.08 \cdot P$	-\$306		
	\$2,560		
<p><i>These calculations matter in health insurance. For this worker, one dollar in cash payments results in only about 64 cents in after-tax income. Accordingly, as long as a dollar’s worth of health insurance is worth more than 64 cents, he or she will prefer insurance to cash.</i></p>			

3.14. How different would this calculation look for a worker who earned \$500,000 and lived in Vermont? This worker would face a state income tax rate of 9.5 percent and a federal income tax rate of 35 percent. *This worker would pay additional federal income taxes of \$1,400 and additional state income taxes of \$380. As a result, her take-home pay would only go up by \$2,220, or 56 cents per dollar. So, the tax advantage of getting health insurance instead of cash is larger for this worker (and would be even if we factored in Medicare and Social Security taxes).*

Case 3.1: Federal Employees Health Benefits Program as the Model for Marketplace Plans

Discussion questions:

- One plan costs \$8,000. The government will pay \$6,500. How much would a \$10,000 plan cost the employee? *The employee would pay \$3,500.*
- Is equal government payment important, regardless of the plan the employee chooses? *Yes, it exposes the employee to the full incremental cost of a more expensive plan. This means that employees pay more attention to the costs of coverage.*
- How does equal payment affect employees’ choices? *Equal premiums encourage employees to choose less expensive plans.*
- Would varying premiums (such as premiums based on age) work better, so that older employees would be attractive risks for insurers? *They might, although there are tradeoffs between pricing insurance so that all groups of customers represent good risks, pooling risks over the largest groups possible, and keeping insurance as simple as possible.*
- What problems would varying premiums cause? *It might increase the number of uninsured workers, as older, low-income workers gamble that they will not get sick.*
- Why didn’t insurers for the Federal Employees Health Benefits Program take aggressive steps (like creating narrow networks) to bring down premiums? *It did not seem to be necessary to compete successfully for customers, because no other insurers were taking the steps either. And workers’ direct payments were modest, so there was little pressure from*

customers to take these steps.

- Why do the high incomes of federal employees affect their choices? *Consumers with high incomes tend to be less price sensitive than consumers with low incomes. In the context of insurance, they tend to buy more generous plans that offer better protection against financial and medical risks. Because their tax rates are higher, they may also want coverage that turns predictable after-tax spending into pre-tax spending on insurance premiums.*

Case 3.2: Group Health Cooperative’s Patient-Centered Medical Home

Discussion questions:

- Why would it make sense to become a network model HMO? *By becoming a network model HMO (one that signs contracts with some of its providers rather than owning them), Group Health could expand at lower cost.*
- Would you like to get your primary care at a patient-centered medical home? *This depends on personal preferences, so no right answer is possible. It may be a useful way to explore the features of patient-centered medical homes.*
- Did it make sense for Group Health to support the patient-centered medical home transition? *Group Health is an insurer as well as a provider of care. For an insurer, a patient-centered medical home offers a way of reducing medical costs. For a provider, a patient-centered medical home offers a practice environment that patients, doctors, and nurses prefer. This makes it easier to add patients and attract staff.*
- Could an independent practice afford to become a patient-centered medical home? *Perhaps it could if most of its competitors were patient-centered medical homes. Being a patient-centered medical home might be required to be an effective competitor. Otherwise, a patient-centered medical home adds costs and may reduce revenue, making it a problematic choice for an independent practice.*
- Why is Medicare sponsoring patient-centered medical home demonstrations? *Medicare wants to save money, improve beneficiaries’ experience of care, and improve beneficiaries’ health. A patient-centered medical home helps with all of these goals.*
- How would a 6 percent reduction in hospitalization rates affect hospitals? *They would become less profitable. As much as half of a hospital’s costs do not vary with volume, so a reduction in volume reduces revenue more than cost.*

Chapter 3

An Overview of the Healthcare Financing System

After mastering this material, students will be able to

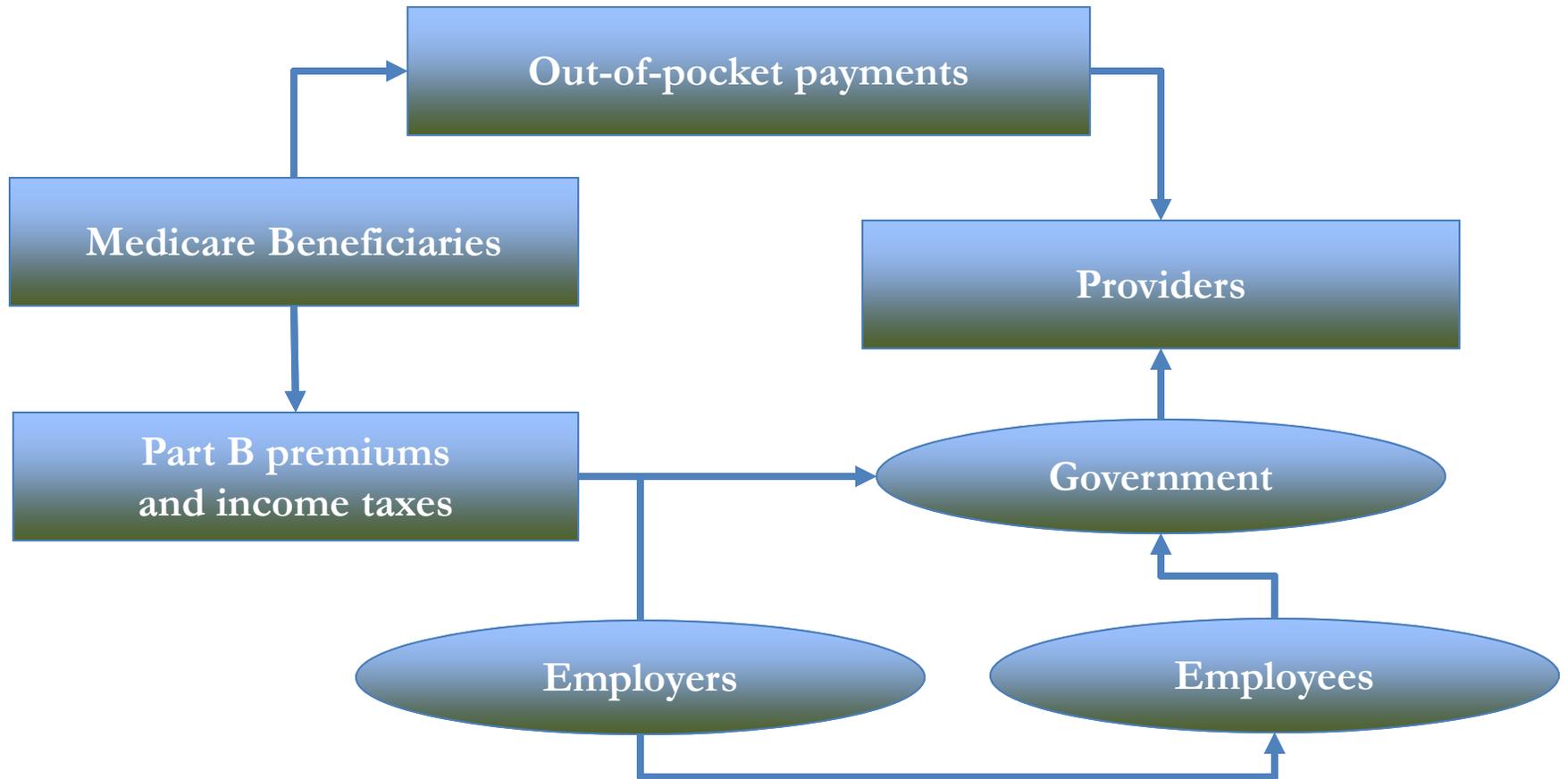
- **explain why health insurance is common,**
- **identify major trends in insurance,**
- **use standard insurance terminology,**
- **describe major insurance problems, and**
- **find insurance information.**

WHO PAYS FOR HEALTHCARE?

Consumers pay for healthcare.

- **Directly, via out-of-pocket payments**
- **Indirectly, via**
 - insurance premiums,
 - wage reductions, and
 - taxes.

The Flow of Funds in Medicare



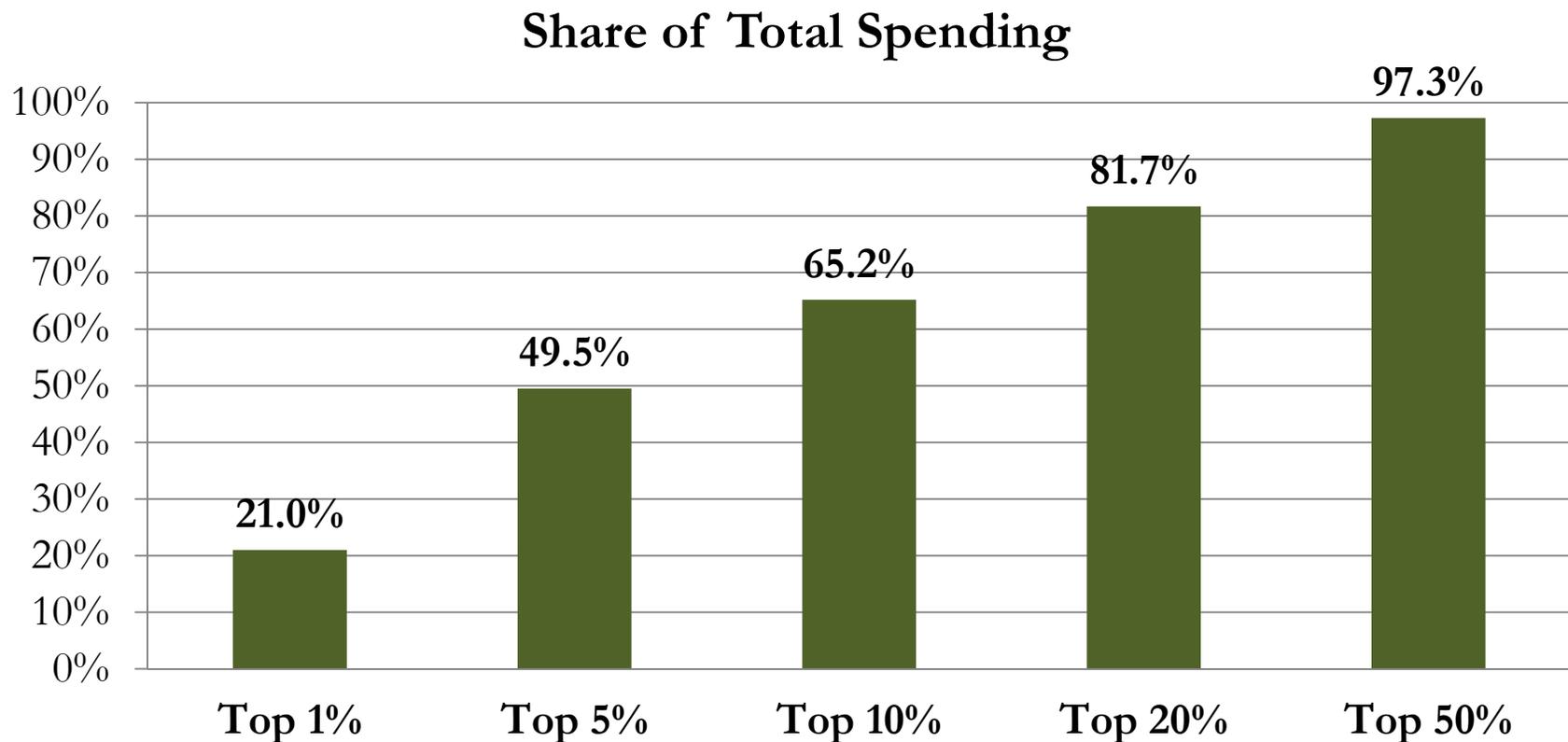
Financing is important.

- **We pay for most care indirectly via**
 - premiums,
 - wage reductions, and
 - taxes.
- **How we pay for care influences**
 - what providers recommend, and
 - what patients choose to do.

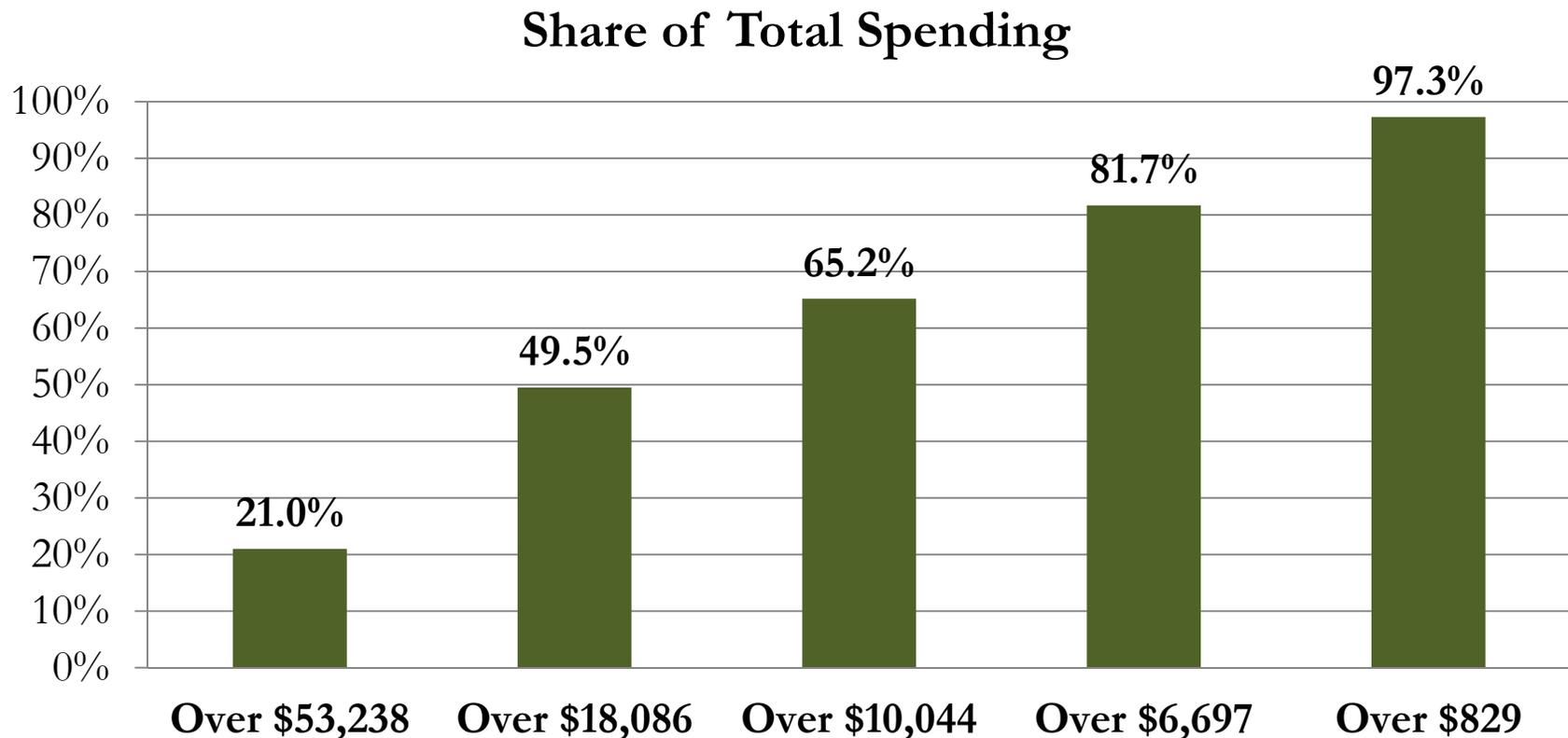
A few people have very high healthcare costs.

WHY INSURANCE?

A few people have very high costs.

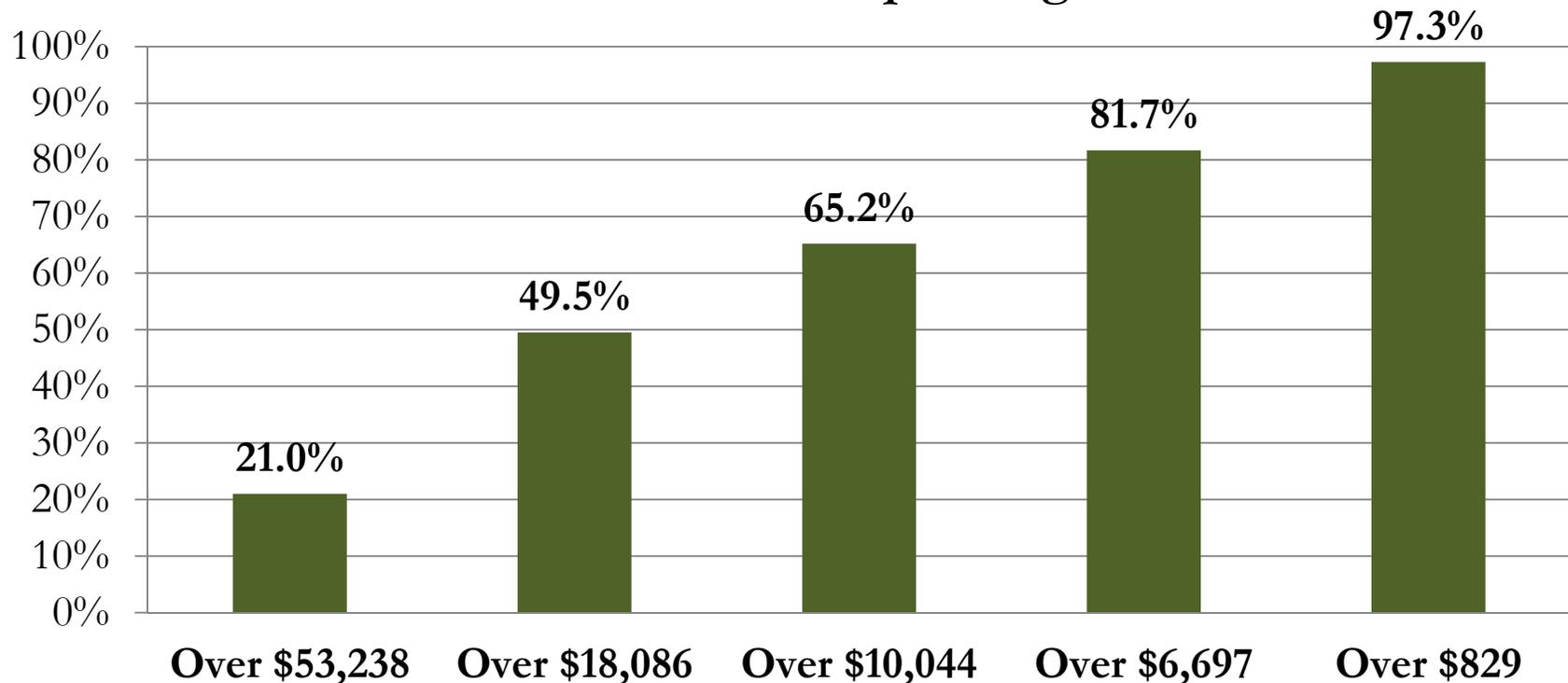


What does this mean in dollars?



How would you cope with healthcare bills of more than \$50,000?

Share of Total Spending



Insurance

- **pools the risks of healthcare costs;**
- **affects how and how much**
 - consumers pay and
 - providers get; and
- **affects incentives.**

Fee-for-service (FFS) insurance pays a share of the billed amount.

- **For a bill of \$100,**
 - the customer pays 20 percent or \$20, and
 - the insurer pays 80 percent or \$80.

FFS pays a share of the bill.

- **For a bill of \$100,**
 - the customer pays \$20, and
 - the insurer pays \$80.
- **For a bill of \$200 or two bills of \$100,**
 - the customer pays \$40, and
 - the insurer pays \$160.
- **What problems does this create?**

Managed Care Insurance

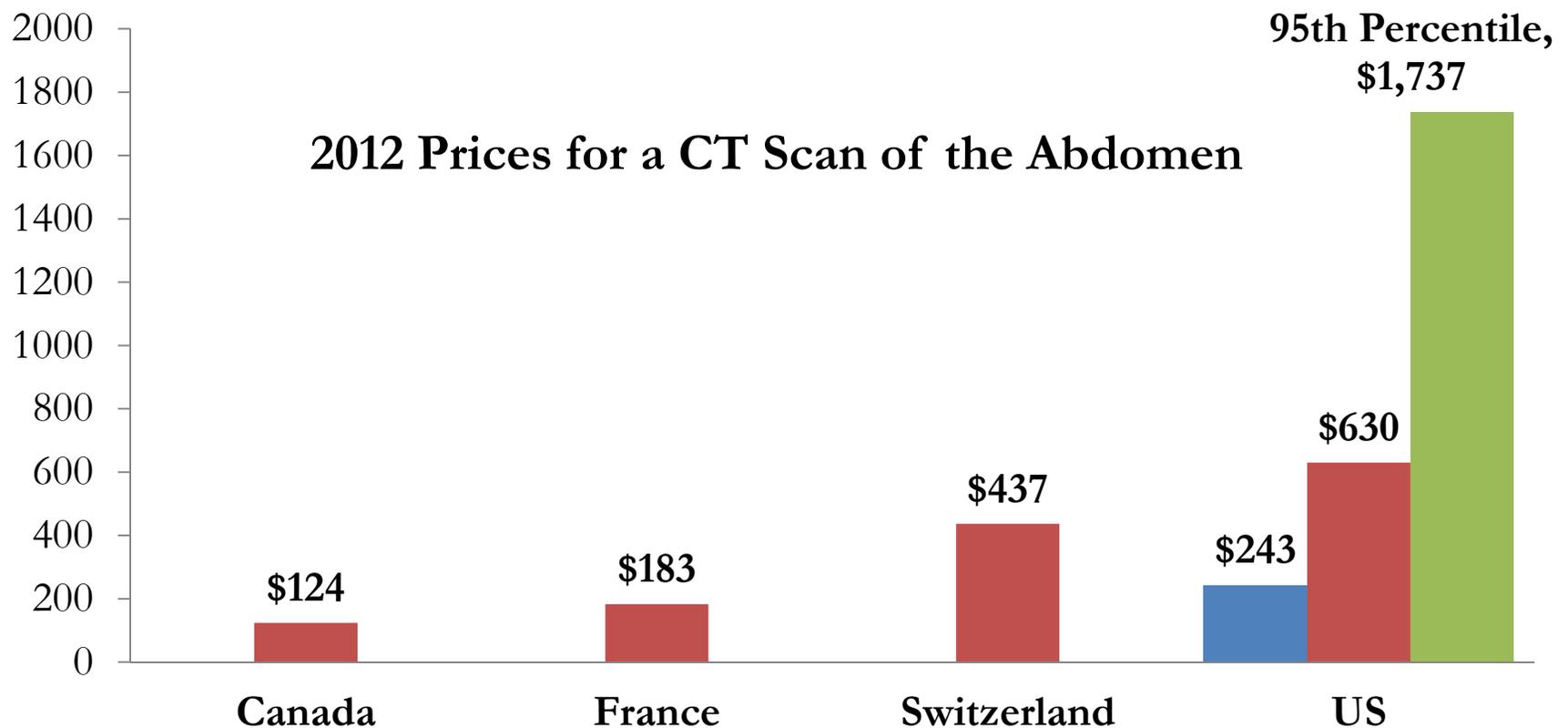
- **A reaction to the shortcomings of FFS**
 - Negotiated discounts
 - Utilization review
 - Steering customers to low-cost providers
- **A reaction to variability of care**
 - Cost
 - Quality

Preferred provider organizations are the most common type of managed care.

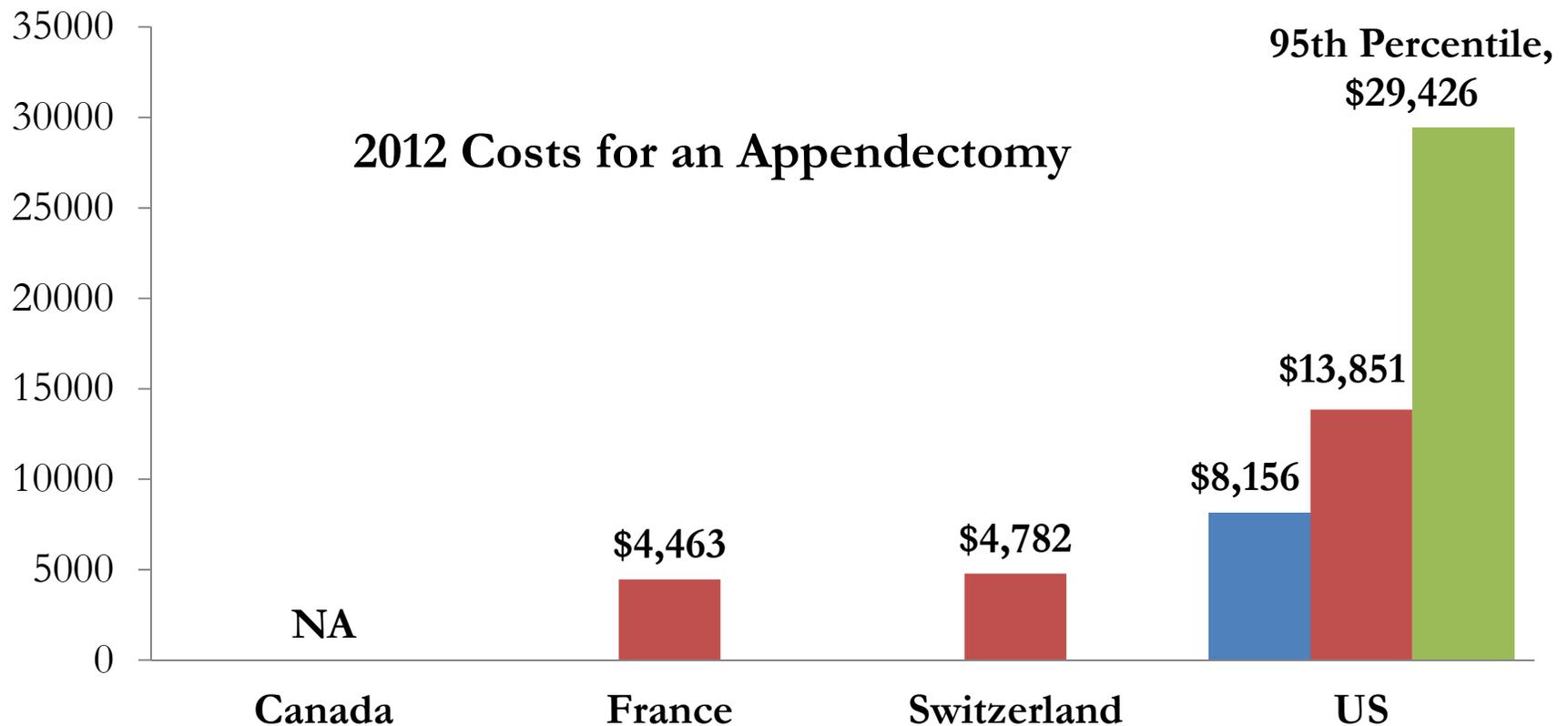
- **Preferred can mean**
 - willing to accept a discount, and
 - acceptable quality.

PRICES AND INSURANCE

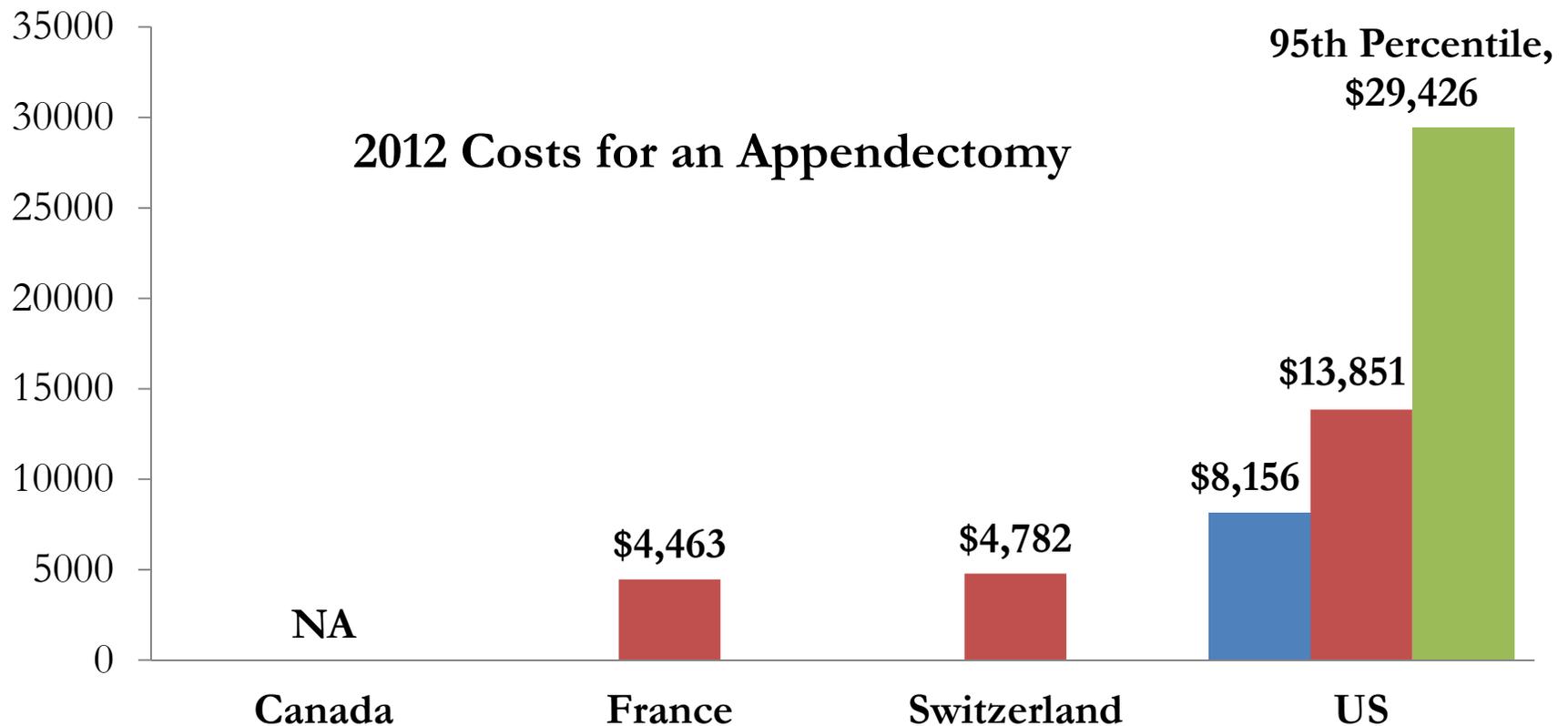
US prices are high and variable.



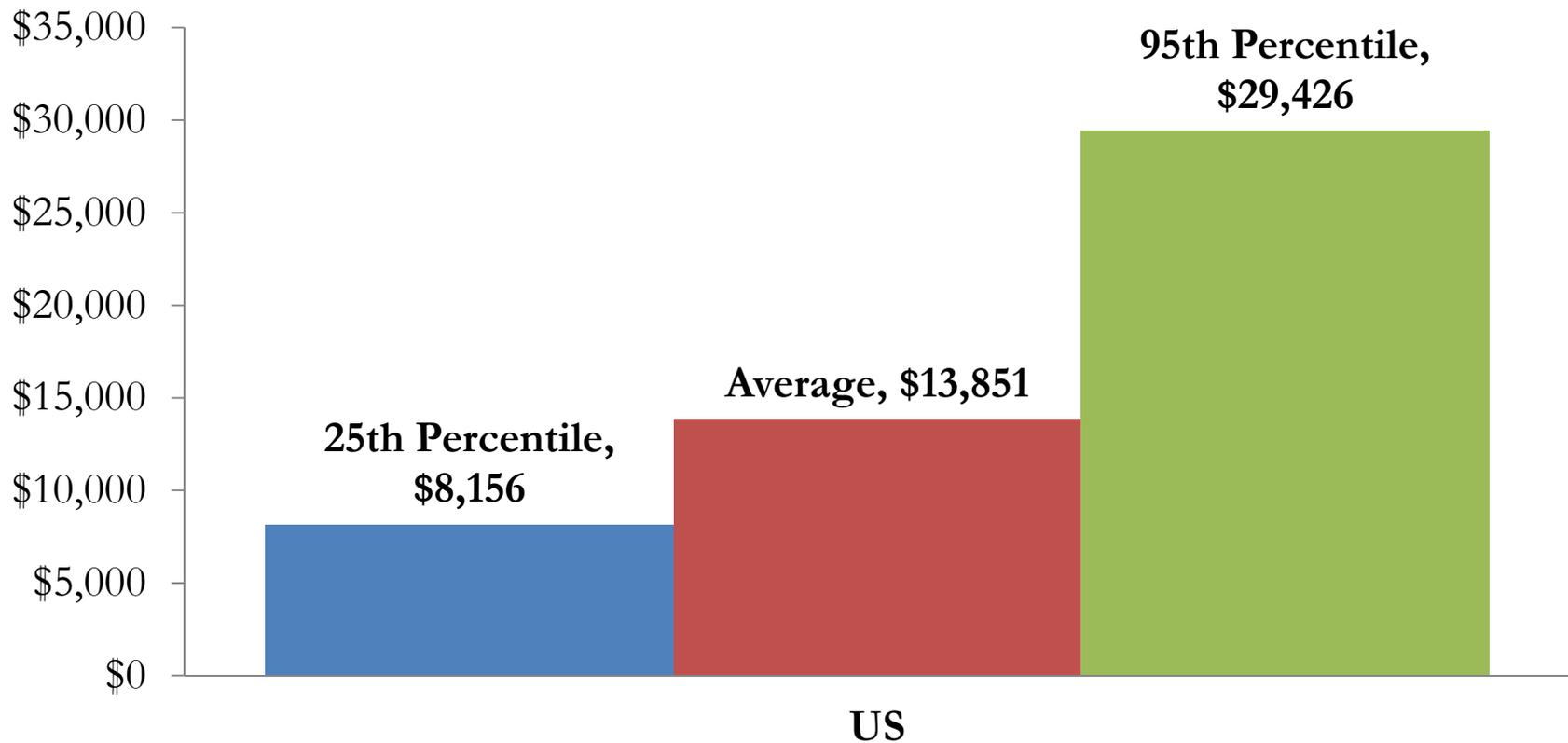
US prices are high and variable.



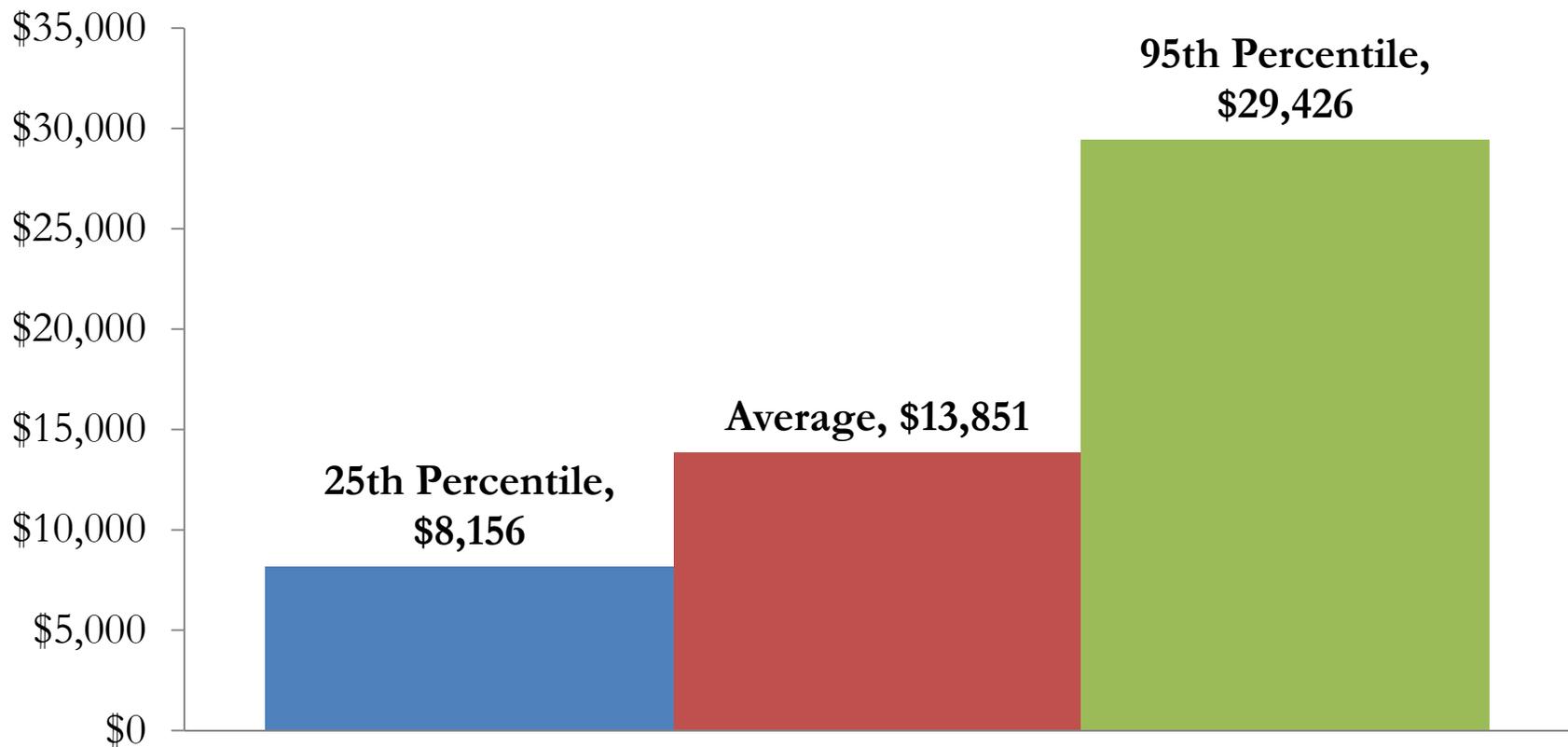
US costs are mostly the result of high private prices.



US prices are high and variable.



How would you feel if you paid \$20,000 for an appendectomy?



Data from an Actual Claim

- **Amount charged:** \$152
- **Amount negotiated:** \$100
- **Patient copayment:** \$25
- **Insurance payment:** \$75

What would you pay?

- **Amount charged:** \$152
- **Amount negotiated:** \$100
- **Patient copayment:** \$25
- **Insurance payment:** \$75

**If you had to pay \$152,
would you be less likely to go?**

- **Amount charged: \$152**
- **Amount negotiated: \$100**
- **Patient copayment: \$25**
- **Insurance payment: \$75**

Quiz: What is “moral hazard”?

- A. Personal failings of healthcare providers**
- B. Personal failings of healthcare consumers**
- C. Insured customers use more care**
- D. Fraud and abuse in healthcare**

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Data from Another Actual Claim

- **Amount charged:** \$153.43
- **Amount negotiated:** \$22.66
- **Patient copayment:** \$0.00
- **Insurance payment:** \$22.66

What would happen if the charge increased to \$200?

- **Amount charged: \$153.43**
- **Amount negotiated: \$22.66**
- **Patient copayment: \$0.00**
- **Insurance payment: \$22.66**

PAYMENT SYSTEMS MATTER

Robinson on Payment Systems

“There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary.”

Objectives

- **Describing payment systems**
 - How providers get paid
 - How much providers get paid
 - How patients pay
 - How much patients pay
- **Forecasting**
 - Patient and provider responses
 - The shape of future payment systems

Payment systems are important.

- **They affect incentives for**
 - providers,
 - patients, and
 - insurers.
- **They affect care via**
 - what gets provided,
 - who provides it, and
 - where it gets provided.

Payment systems have many dimensions.

- **How providers get paid**
- **How much providers get paid**
- **How patients pay**
- **How much patients pay**

These dimensions matter.

- **Providers want to produce more**
 - if it increases payments to them, and
 - if the product is profitable.
- **Patients want to buy more products**
 - that providers recommend to them,
 - that are covered by insurance, and
 - that cost little, compared with benefits.

How do physicians get paid?

- **Per hour (salary)**
- **And?**

How Providers Get Paid

- **Per hour (salary)**
- **Per defined procedure (FFS)**
- **Per case or episode of care (case rate)**
- **Per patient (capitation)**

These payments can be modified.

- **Combining mechanisms**
 - Salary plus a case rate for some services
 - Capitation plus FFS for selected services
- **Adding incentives**
 - Capitation plus immunization bonus
 - Case rate plus gain sharing

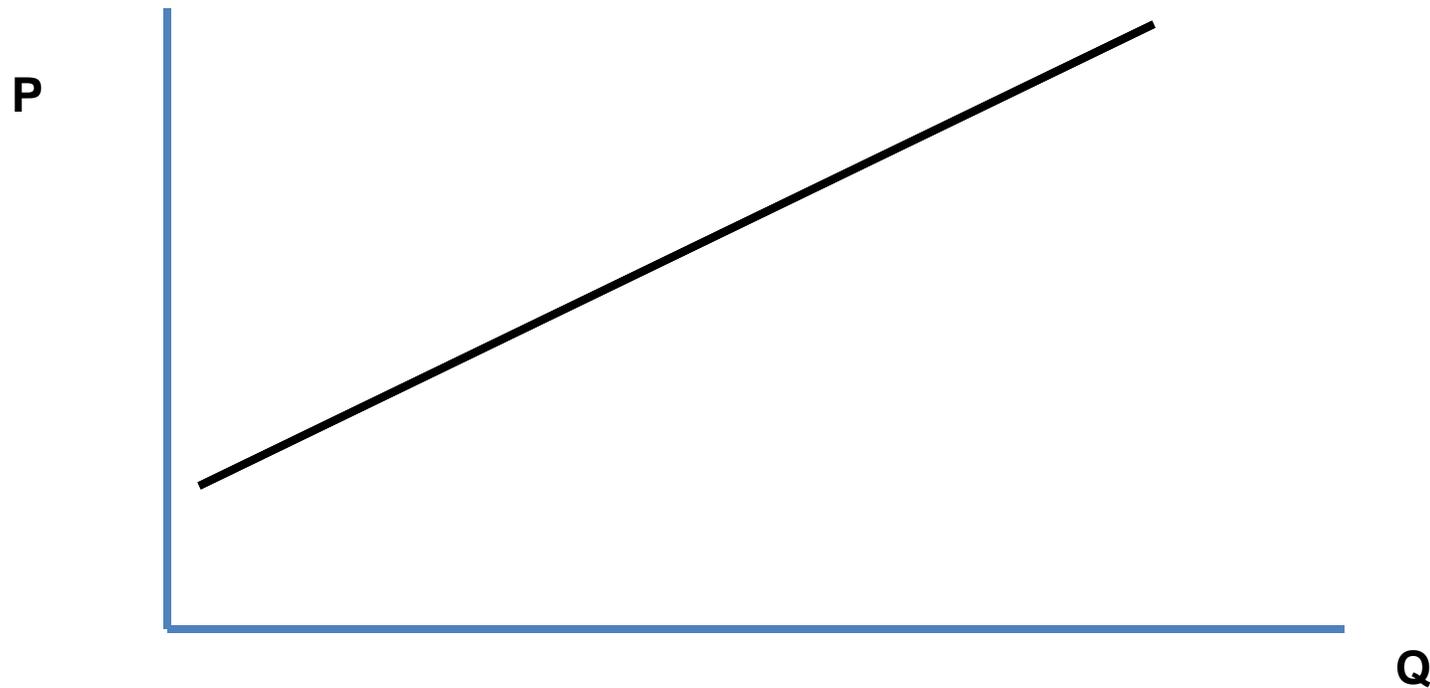
The details can be important.

- **What's included?**
- **For what is the provider at risk?**
 - Treatment of extra services?
 - Treatment of high-cost services?
- **Can the provider charge extra?**

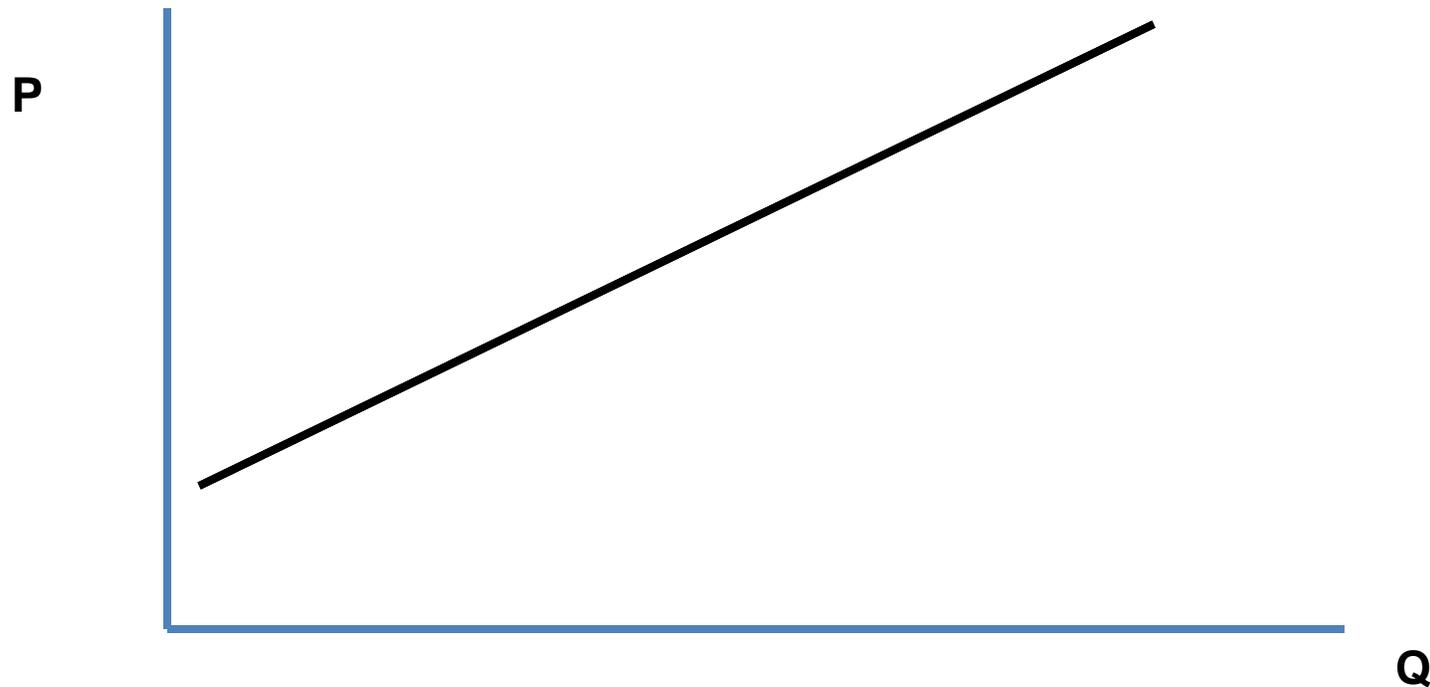
How Much Providers Get Paid

- **Individual providers can**
 - increase output because of higher fees, and
 - reduce output because of higher incomes.
- **But high fees increase service supply.**
 - Some providers produce more.
 - More providers start serving customers.
- **Low fees reduce service supply.**

Supply curves mostly slope up.



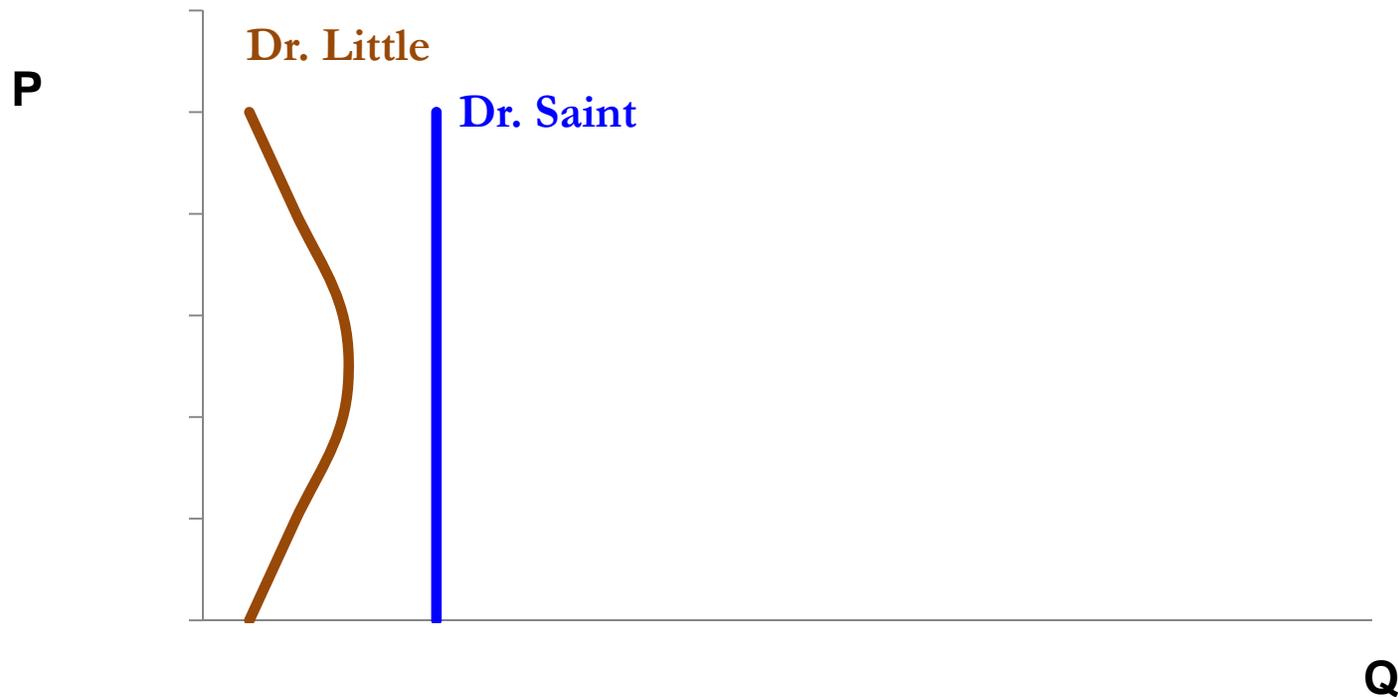
What does it mean that supply curves mostly slope up?



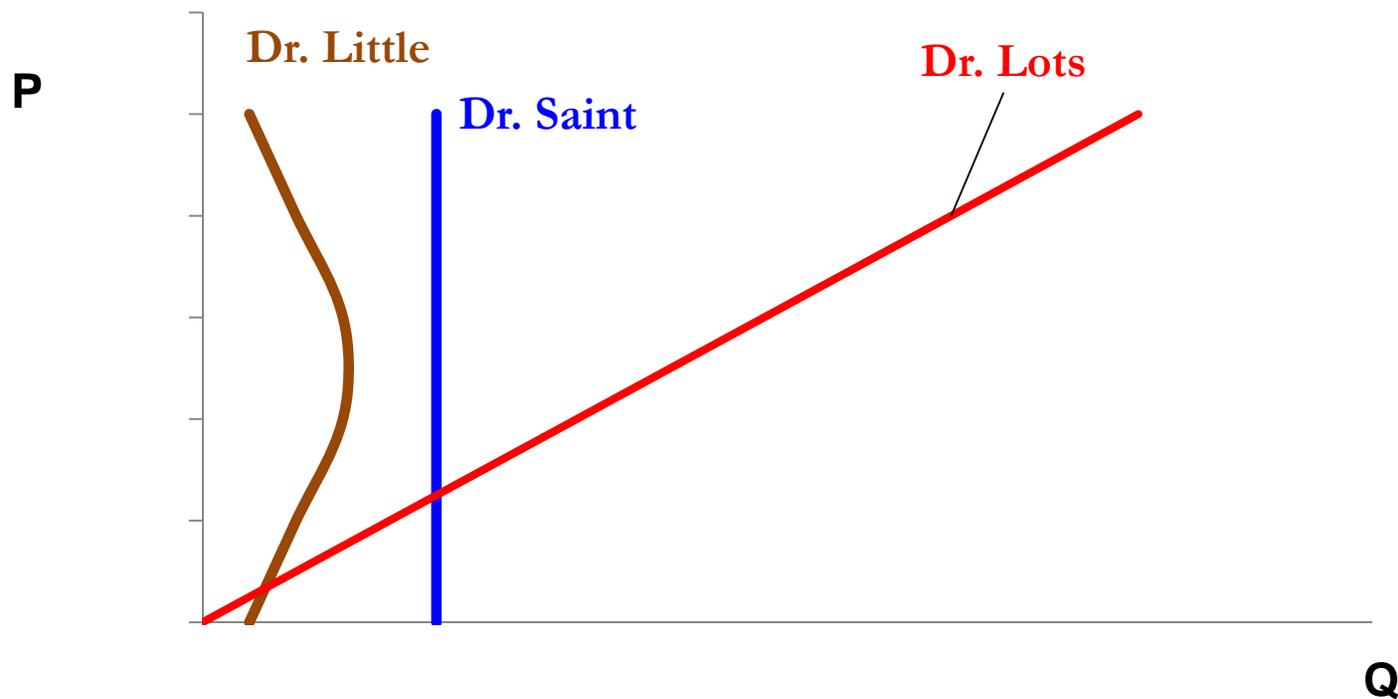
Supply curves usually slope up (even if some respond oddly).



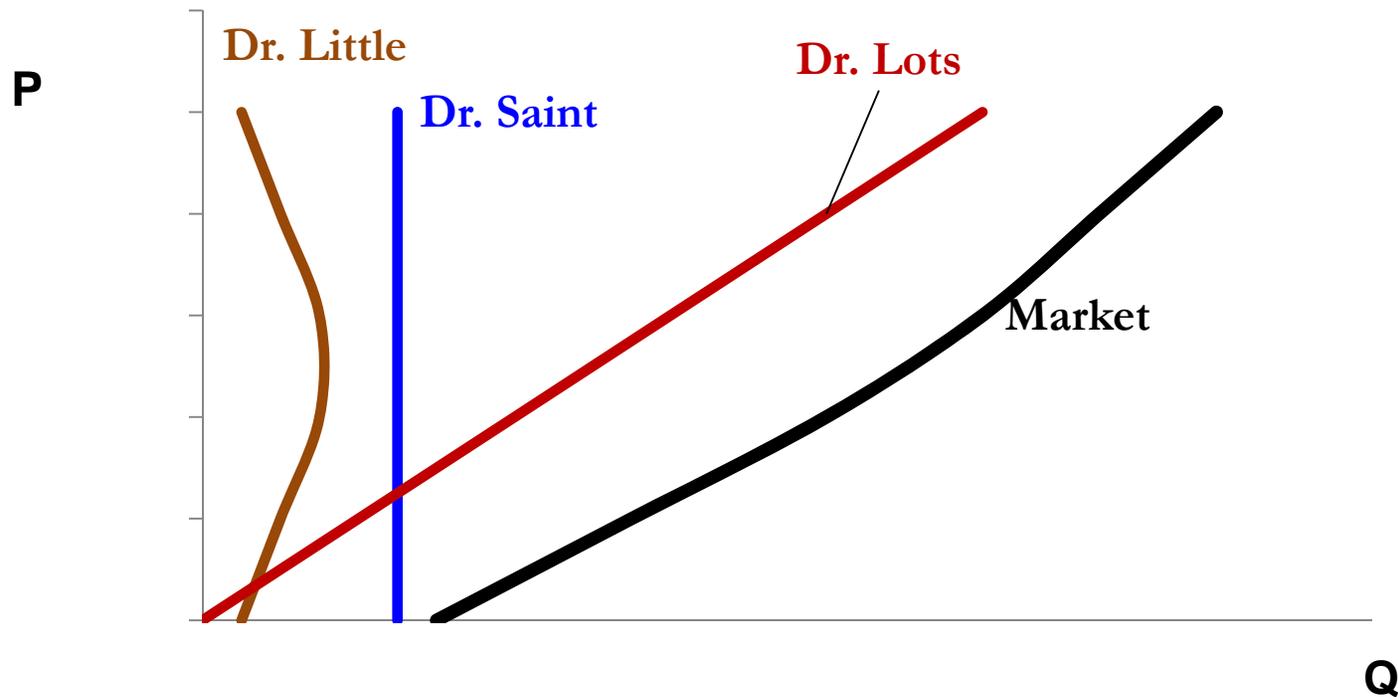
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Supply curves usually slope up (even if some respond oddly).



How Patients Pay

- **Directly (fees)**
- **Indirectly (insurance premiums)**
- **Very indirectly (general taxes)**
- **The more directly patients pay,**
 - the more choices reflect opportunity costs, and
 - the more risk they bear.

How Much Patients Pay

- **High copayments reduce service demand.**
 - This may suggest use is meant to be low.
 - It may also suggest product is not vital.
- **Low copayments increase service demand.**

PAYMENT SYSTEMS

Payment Systems Standards

- **Simplicity**
- **Transparency**
- **Efficiency**
- **Consistency with local norms**

No system meets all these criteria.

Piece Rates

- **Common in healthcare**
 - Fee-for-service
 - Case rates
- **Uncommon elsewhere**
 - Incentives are too powerful.
 - Objectives are too complex.
 - Screening and socialization seem to work better.

Piece Rates

- **What do we want physicians to do?**
- **Why might FFS be a problem?**

What's good about

- **FFS?**
- **case rates?**
- **capitation?**
- **salary?**

What's bad about

- **FFS?**
- **case rates?**
- **capitation?**
- **salary?**

Different patients look profitable in different systems.

- **Complex illnesses needing many tests are**
 - very profitable under FFS,
 - very unprofitable under case rates and capitation, and
 - neither under salary.
- **Simple illnesses needing minimal care are**
 - unprofitable under FFS,
 - profitable under case rates and capitation, and
 - neither under salary.

Future payment systems are likely to

- **blend a variety of financial incentives,**
- **keep financial incentives**
 - aligned with goals and
 - not too strong, and
- **rely more on nonfinancial incentives such as**
 - promotions and
 - celebrations.

CONCLUSIONS

Consumers pay for healthcare.

- **Directly, via out-of-pocket payments**
- **Indirectly, via**
 - insurance premiums,
 - wage reductions, and
 - taxes

Insurance is common.

- **More than 85 percent of the US population has it.**
- **It pools the risk of high costs.**
 - It also complicates things.
 - It changes incentives.
- **Most of us have group plans.**
 - Employment sponsored
 - Government sponsored

Individual plans are becoming more common.

- **Medicare Advantage**
- **Affordable Care Act (ACA)**
- **This may change the entire system.**

Incentives and outcomes depend on

- **how providers get paid,**
- **how much providers get paid,**
- **how patients pay, and**
- **how much patients pay.**

Incentives must be used cautiously.

- **Patients and providers may respond**
 - too much, and
 - in undesired ways.
- **Managed care seeks to change them.**

Designing incentives is hard.

- **There will be responses.**
- **They may not be the desired responses.**
 - Changes in documentation
 - Changes in who gets seen
 - Truly perverse responses

Designing incentives is hard.

- **The goals must be clear:**
 - Improved average quality, versus
 - More patients getting good quality
- **Process versus outcome**
 - How care is delivered
 - How patients do
 - A mixture

Financing is important.

- **We pay for most care indirectly.**
- **How we pay for care influences**
 - what providers recommend,
 - what patients choose to do, and
 - outcomes.