

TOPIC—Who Pays for Healthcare in America?

OBJECTIVES—

- 1) Identify and describe federal and state entitlement programs which provide healthcare services—Medicare and Medicaid and SCHIP.
- 2) Define and describe commercial insurance and the various plans they offer.
- 3) Describe the issue of the uninsured and the underinsured in America.

CONTENT—

Medicare—A national entitlement program, run by the federal government, that provides health services funding to eligible individuals. It is administered by the Centers for Medicare and Medicaid Services, a federal agency within the Department of Health and Human Services.

Medicare is a health insurance program for:

- People age 65 or older
- People under 65 with certain disabilities
- Any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Part A

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice and home health care

Medicare Part B

- Helps cover physicians' services and outpatient care
- Helps cover some preventive services

Medicare Part D

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

There are several plan choices for eligible individuals to make—original Medicare, Medicare Advantage Plans, and other Medicare Health Plans

Medicaid—The Medicaid program is jointly funded by the federal government and the states. As a result, it varies from state to state. It is targeted at medically indigent individuals. States have a certain degree of flexibility in the determination of which benefits they will provide, who will be eligible, and in the specific arrangement of services.

All state Medicaid programs generally cover hospital inpatient and outpatient services, physician and other professional services, and long term care services, some nurse-provided services, some educational programs, screening services and to a varying degree dental care. Optional services under federal guidelines may extend the minimum required services to include a wider array of clinical care, drugs, eye care and enhanced dental care.

State Medicaid programs do not pay providers particularly well.

State Children's Health Insurance Program (SCHIP)—This program is jointly financed by the federal and state governments and administered by the states. Each state defines eligibility rules, but in most states, it covers uninsured children under 19 whose families earn up to \$36,200/year for a family of four. It pays for doctor's visits, immunizations, hospitalizations and ER visits for little or no cost.

Commercial Insurance—Private insurance companies, like Aetna and Cigna, provide a full range of insurance products to their customers.

Many individuals have group insurance coverage provided by their employers. The employer pays an annual premium to a health insurance provider for a health plan that is offered to employees. Employees may pay a percentage of this premium to receive the health benefits.

Individual insurance may also be purchased by a person or family with premiums varying by age, health status and other factors.

Types of Plans include—

Indemnity or Fee-for-service Plans—Traditional insurance plans in which the individual pays a pre-determined percentage of the cost of healthcare services and the insurance company pays the other percentage. The individual can choose any provider and a typical plan may cover 80% of charges while the individual is responsible for the other 20%.

Health Maintenance Organization (HMO)—HMOs represent an insurance option in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fee remains the same regardless of the services provided. They generally provide comprehensive healthcare services including some preventive care. In most instances, the insured must seek services within the HMO or there is no coverage. For example, the insured may be covered at 100% if healthcare services are provided by the HMO, but if the individual chooses to go to a provider who is not part of the HMO, there is no coverage.

Preferred Provider Organization (PPO)—In a PPO, the insurance carrier contracts with physicians and hospitals to establish a network of participating providers. The providers offer discounted, pre-negotiated fees for their services and the insurance company offers

incentives to their enrollees to use the PPO. For example, the insured may be covered at 90% if healthcare services are provided by the PPO, but if the individual chooses to go to a provider who is not part of the PPO, the services are covered at 70%.

There are many variations on these types of plans. It is important that you read your benefit plan provisions carefully and choose a plan which best fits your needs and/or the needs of your family.

The Uninsured

Nearly 16 percent, or roughly 46 million Americans have no health insurance and the number of Americans who are underinsured, i.e., those who have inadequate health insurance is estimated at 25 million. As the economy worsens and unemployment figures rise, the numbers will continue to grow.

Healthcare reform is a critical challenge confronting our country. Issues to address include: universal access, administrative efficiency, cost containment, enhanced management and use of health information, technological innovation, quality outcomes for appropriate and medically necessary healthcare services.

RESOURCES

www.cms.org

Official website for Centers for Medicare and Medicaid Services.

www.healthinsurance.org

This site provides understandable consumer information on health insurance.