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HHS 8000

Midterm Exam 2008

90

1. Explain each mode of physician reimbursement: fee for service, episode of illness, capitation, and salary. Explain each mode of hospital reimbursement: fee for service, per diem, episode of illness (DRGs), capitation and global budget.

Physicians are reimbursed through a variety of methods: fee for service, episode of illness, capitation, and salary. The term **fee for service** refers to paying health care providers based upon a fee for each health service provided. For example, a physician is paid for an office visit, for a procedure such as a CT scan, or for providing supplies to a patient. **Episode of illness** is a method of reimbursement in which the physician is paid for all services provided during one occasion of illness, including surgical procedures performed and care provided after surgery. examples **Capitation** is a method of reimbursement where a single payment is made for each patient's treatment and care in either a month or year period. The physician is given a set amount of money for each of his or her patients, either each month or each year. This form of reimbursement allows the physician to receive payment for each patient visit, so in order to earn more, physicians must schedule as many appointments as they can. Different from private physicians, some physicians work in the public arena at Veterans Affairs and military hospitals, state mental hospitals, and community clinics. In general, public physicians are usually paid one lump sum in the form of a **salary**. This salary is based on services provided during the period of one month or year.

adv. vs disadvtages

Many hospital reimbursement methods are similar to those of physician reimbursement and these include fee for service, per diem, episode of illness (DRGs), capitation, and global budget. The **fee for service** methods provides reimbursement for each service rendered to the patient. Under this method, an insurance company or patient would receive an itemized bill detailing all services and/or procedures provided during the patient's stay. **Per diem** reimbursement is when the hospital collects one large sum of money for every day that a patient is in the hospital. This form of reimbursement does not take into account services provided or procedures performed during a patient's stay but rather, the amount of days a patient is in the hospital. Because this a common form of reimbursement, length of stay is an important issue in hospital reimbursement. The **episode of illness** type of reimbursement utilizes diagnosis-related groups (DRGs), which are organized by Medicare, to pay hospitals. Medicare pays the hospitals for each admission, based on the patient's diagnosis or DRG. This payment includes all services rendered during the episode of illness, which involves certain risks. Because two patients may be admitted with the same diagnosis, yet one stays for a day and the other stays for two weeks, Medicare is at risk because they are paying the same amount for both patients. **Capitation** within hospital systems is payment for all services provided to all patients during a specified time period, typically a month or a year. Hospitals receive a sum for all treatments and procedures a patient receives during this time period. Unfortunately, whether these services are utilized and/or length of stay is irrelevant as far as payment goes. **Global budget** is a type of reimbursement in which a hospital is paid a large sum for all services provided in one year. This payment is to cover all expenses regardless the number of patients, illnesses, procedures, etc. examples?

References:

Bodenheimer TS, Grumbach K. *Understanding Health Policy, A Clinical Approach.* 4th edition. McGraw-Hill. 2005.

Which ones are used and not used commonly today? Conclusions?

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Kiplinger. Fee-for-Service Health Coverage. [Available online] Accessed at http://www.kiplinger.com/basics/archives/2003/11/fee.html. October 7, 2008.

5. Discuss EMTALA and how is the term "patient dumping" associated to this federal act?

EMTALA, or the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, was in fact created in 1986 as part of the Consolidated Omnibus Reconciliation Act in an effort to prevent what is known as "patient dumping." Patient dumping is the act of refusing to treat poor or uninsured persons who need care and was common practice by private hospitals attempting to avoid uncompensated costs associated with treating the poor. In general, EMTALA provides individuals with the right to be treated and stabilized within the emergency department of participating hospitals, those hospitals receiving payment from the Department of Health and Human Services, CMS under Medicare. In essence, almost every hospital in the United States is in such an agreement with the exception of some military hospitals and the Shriners' Hospital for Crippled Children. The provisions of this law apply not only to Medicare patients but also to any patient who presents at the emergency department requesting treatment. By law, the patient must be screened and examined to determine his emergency status; if his status is deemed an emergency medical condition, the hospital must treat him until he is stable or transfer him to another hospital according to the law's orders. Because of the magnitude of EMTALA, I will not attempt to discuss it in its entirety, rather, provide an outline of the more pertinent facts in relation to this question.

1. What are the specifications of EMTALA?

- Hospitals are obligated to medically screen and examine any patient presenting to the emergency department in order to determine whether a medical emergency exists.
- Hospitals are restricted from transferring patients with a medical emergency or who are in active labor regardless of economic status.
- Hospitals have a duty to treat those medical emergencies.

2. What qualifies as a medical emergency?
   - A definition is provided though it is more a medical one than legal:

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or

"With respect to a pregnant woman who is having contractions --that there is inadequate time to effect a safe transfer to another hospital before delivery, or

that the transfer may pose a threat to the health or safety of the woman or her unborn child."

3. When is patient transfer appropriate?
   - Patient transfer to another hospital is considered appropriate when the patient is stabilized (when there is not a likelihood of the patient's status declining as a result of or during the transfer) or if the patient is not experiencing a medical emergency.

4. What is deemed an appropriate transfer?

Creative way to answer — I like the format-

- According to EMTALA, there are several important components of an appropriate patient transfer, including:
- The hospital having treated and stabilized the patient to the best of their ability
- The patient requiring care from the receiving hospital
- Physician documentation of the benefits of transfer outweighing the risks
- The receiving hospital's agreement to the transfer and their availability
- Medical records must be given to the receiving hospital
- The transfer is performed under the best of conditions with the proper and necessary equipment

5. Are there penalties for violation?

- Hospitals and physicians may be subject to a civil money penalty for violation of EMTALA
- The federal government, patients, and hospitals that are on the receiving end of patient dumping may all instigate measures against a hospital in violation with EMTALA

Any conclusions - Is this the way we should go or are there other alternatives to consider?

References:

Teitelbaum J, Wilensky S. *Essentials of Health Policy and Law.* Jones and Bartlett Publishers, Inc. 2007.

Griffin D. Hospitals: *What they are and How they work.* 3rd edition. Jones and Bartlett. 2006.

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7. What populations or types of people pay more under experience rating? Under community ratings? Do community and experience ratings create any incentives for individuals to act in a certain way? Which system seems preferable to you?

Experience and community rating are two methods used by insurance companies when setting premiums. Experience rating takes into account individuals' previous expenditures and medical costs from the previous year when determining the premium for the next year. Thus, individuals with high costs will likely experience a rise in their premiums and vice versa. Community rating on the other hand does not consider these factors as it only looks at geography and family composition. In community rating, individuals within a group are all charged the same premium if under "pure" community rating. Sometimes modified community rating is used and this can take into account other factors such as gender and age.

Premiums based upon experience rating would definitely affect the way an individual behaves. If one knows that his or her insurance premium could potentially increase based upon his last years "performance," he will theoretically be motivated to take better care of himself in order to prevent such an increase. It is difficult to say whether community rating affects individuals' behavior. If everyone were paying the same premium regardless of their medical costs, I would think it would be difficult to motivate people. The healthy may try to stay healthy for their own benefit, but the non-healthy individuals may not.

Whether insurance premiums should be based upon experience or community rating is a sensitive debate with many facets including social concerns and privacy issues. Because community rating is less common than it once was, those groups and individuals whose medical costs are higher are charged higher premiums. This often results in discrimination against those with chronic illnesses, especially in the workplace. Many employers hesitate to hire the chronically ill or those with chronically ill dependents as their health insurance premiums will likely increase. This is one of the arguments used by the supporters of community rating.

Within community rating, more specifically pure community rating, insurers charge the same premium price to each individual regardless of their medical history, age, gender, health risks, etc. This type of system thus allows the sick and healthy to pay the same amount for health insurance. In essence, a sixty and twenty five year old man would pay the same premium when in reality, the sixty year old man's health costs are often triple to quadruple that of his twenty five year old counterpart.

Within this type of system, healthy people are almost inevitable charged more in order to create balance and allow the insurers to charge the sick less. The risk here is that when healthy people see their premiums rise, many will decide against health insurance and combined with those who cannot afford it, lessen the amount of those insured. This lesser amount of insured individuals would include the less healthy who would see premiums rise further due to the smaller pool of those insured. Those in favor of community ratingsacknowledge the increase in premium amounts that would result for healthy people; however, they dispute that when distributed to everyone insured, the increased rates would actually be minimal.

In a perfect world, I would support the idea of experience rating. I believe that we should all be held responsible for our health and those of us who maintain it should be rewarded-reflected by our health care insurance premium. I understand there are unforeseen medical emergencies and accidents happen to the healthiest of individuals, but theoretically speaking, I prefer experience rating. Though I have limited experience with insurance thus far, I know I would not be pleased to pay a higher premium as a healthy individual in order to cover those who are not healthy (by choice). This issue conflicts me, as I believe that every individual should have the right to healthcare and am distressed that over 40 million individuals are

uninsured. Removing all of those issues from the decision, and based upon the simplest of terms and definitions, I would agree with experience rating.

Good Conclusion

References:

Teitelbaum J, Wilensky S. *Essentials of Health Policy and Law.* Jones and Bartlett Publishers, Inc. 2007.

Health Insurance. Community Rating vs. Experience Rating. [Available online] Accessed at http://www.healthinsurance.info/HICOMM.HTM. October 7, 2008.

National Center for Policy Analysis. Community Rating. [Available online] Accessed at http://www.ncpa.org/w/w37.html. October 7, 2008.