CHAPTER 3

THE THIRD-PARTY-PAYER SYSTEM

Learning Objectives
After studying this chapter, readers should be able to:

- Describe the key features of insurance.
- Discuss, in general terms, the reimbursement methods used by third-party payers, and the incentives and risks that they create for providers.
- Describe the major types of third-party payers.
- Discuss the specific reimbursement methods used by Medicare.

Introduction
In general, businesses in the healthcare sector that do not provide products or services directly to patients have the same operating environment as businesses in any other industry. For example, Cincinnati Milicron, a machine tool manufacturer, and General Electric’s Medical Equipment Division sell their products in roughly the same way. Cincinnati sells its machines directly to manufacturers that use the machines to produce other goods, and GE Medical sells its diagnostic equipment directly to hospitals, medical practices, and other organizations that use the equipment for diagnostic testing. The prices that the two firms charge for their products are set in the competitive marketplace, and it is relatively easy for buyers to distinguish among competing products. In general, the more expensive the product, the better the performance, where performance can be judged on the basis of a set of more or less objective measures. Thus, in some industries in the healthcare sector, and in most other industries, the consumer of the product or service (1) has a choice among many suppliers, (2) can distinguish the quality of competing goods or services, (3) makes a (presumably) rational decision regarding the purchase on the basis of quality and price, and (4) pays for the full cost of the purchase.

However, for the most part, the provision of healthcare services takes place in a unique way. First, often there are few providers of a particular service at hand. Next, it is very difficult, if not impossible, to judge the quality of competing goods or services. Then, the decision about which goods or services to purchase is usually not made by the consumer of those goods or services, but rather by a physician or some other clinician. Also, payment to the provider is not normally made by the user of the goods or services, but by a third-party payer. Finally, for most individuals, the purchase of health insurance from third-party payers is totally paid for or heavily subsidized by
employers or government agencies, so patients are insulated from the costs of healthcare. This highly unusual marketplace for healthcare services has a profound effect on the supply of, and demand for, such services. We will leave most of the discussion concerning the market for healthcare services for economics courses, but, to get a better understanding of the unique payment mechanisms involved, we must examine the third-party-payment system in more detail. Thus, in this chapter, we discuss those elements of the payer system that directly affect financial management decisions.

**Insurance Concepts**

To begin our discussion, note that the third-party-payer system is really an insurance system with a wide variety of insurance “companies” that come in all types and sizes. Some are investor-owned, while others are not-for-profit or government sponsored. Furthermore, some “companies” require their policyholders, who may or may not be the beneficiaries of the insurance, to make the policy payments, while other “companies” collect partially or totally from society at large. Because insurance is the cornerstone of the third-party-payment system, an appreciation of the nature of insurance will help you better understand the marketplace for healthcare services.¹

**A Simple Illustration**

To better understand insurance concepts, consider a simple example. Assume that no health insurance exists, and that you face only two medical outcomes in the coming year:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Probability</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay healthy</td>
<td>0.99</td>
<td>$0</td>
</tr>
<tr>
<td>Get sick</td>
<td>0.01</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

Furthermore, assume that every other individual faces the same medical outcomes, and hence “sees” the same odds and costs associated with healthcare. Then, what is your expected healthcare cost, E(Cost), for the coming year? To find the answer, we must multiply the cost of each outcome by its probability of occurrence, and then sum the products:

\[
E(\text{Cost}) = (\text{Probability of Outcome 1} \times \text{Cost of Outcome 1}) + (\text{Probability of Outcome 2} \times \text{Cost of Outcome 2}) \\
= (0.99 \times $0) + (0.01 \times $20,000) \\
= $0 + $200 = $200.
\]
Now, assume that you, and everyone else, make $20,000 a year. With this salary, you can easily afford the $200 "expected" healthcare cost. The problem is, however, that no one's actual bill will be $200. If you stay healthy, your bill will be zero. But if you are unlucky and get sick, your bill will be $20,000, and this cost will force you, and most people who get sick, into personal bankruptcy, which is a ruinous event.

Now, suppose an insurance policy that pays all of your healthcare costs for the coming year is available for $250. Would you take the policy, even though it costs $50 more than your "expected" healthcare costs? Most people would. Because individuals are risk averse, they would be willing to pay a $50 premium over their expected benefit to eliminate the risk of financial ruin. In effect, policyholders are passing the costs associated with the risk of getting sick to the insurer.

Would an insurer be willing to offer the policy for $250? If the insurer could sell enough policies, it could take advantage of the law of large numbers. We know that it is impossible to predict the healthcare costs for the coming year for any one individual with any certainty because the cost will either be $0 or $20,000, and we will not know for sure until the year is over. For any individual, the expected cost of healthcare is $200, but the standard deviation is a whopping $1,990, so there is significant uncertainty about each individual's required expenditure.

However, if an insurance company sells a million policies, its expected total policy payout is one million times the expected payout for each policy, or $1,000,000 × $200 = $200 million. Furthermore, the law of large numbers tells us that the standard deviation of costs to an insurer with a large number of policyholders is \( \sigma / \sqrt{n} \), where \( \sigma \) is the standard deviation for one individual and \( n \) is the number of individuals insured. Thus, payout uncertainty for the insurer, as measured by standard deviation, is only $1,990 / \sqrt{1,000,000} = $1.99 per subscriber, or $1.99 million in total. Given these data, we see that if there were no uncertainty in the $20,000 estimated medical cost per claim, the insurer could forecast its total claims quite precisely. It would collect 1,000,000 × $250 = $250 million in health insurance premiums, pay out roughly $200 million in claims, and hence have about $50 million to cover administrative costs, provide a reserve in case realized claims are greater than predicted by its actuaries, and make a profit. Clearly, with a standard deviation of claims of about $2 million, the $50 million "cushion" should be sufficient to carry out a successful business. The problem for real-world insurers is their inability to forecast the cost of each claim.

**Basic Characteristics of Insurance**

The simple example of health insurance described above illustrates why individuals would seek health insurance, and why insurance companies would be formed to provide such insurance. Needless to say, the concept of insurance
becomes much more complicated in the real world. Insurance is typically defined as having four distinct characteristics.

1. **Pooling of losses.** The *pooling, or sharing, of losses* is the heart of insurance. *Pooling* means that losses are spread over a large group of individuals so that each individual realizes the average loss of the pool rather than the actual loss incurred. In addition, pooling involves the grouping of a large number of homogeneous *exposure units* (people or things having the same risk characteristics) so that the law of large numbers can apply. Thus, pooling implies (1) the sharing of losses by the entire group, and (2) the prediction of future losses with some accuracy based on the law of large numbers.

2. **Payment only for random losses.** A *random loss* is one that is unforeseen and unexpected and occurs as a result of chance. Insurance is based on the premise that payments are made only for losses that are random. We will discuss the moral hazard problem, in which losses are not random, in a later section.

3. **Risk transfer.** An insurance plan almost always involves risk transfer. The sole exception to the element of risk transfer is *self-insurance*, which occurs when a business assumes a risk itself rather than insures the risk through an insurance company. (Self-insurance is discussed in a later section.) Risk transfer means that the risk is transferred from the insured to the insurer, which typically is in a better financial position to pay the loss than the insured because of the premiums collected.

4. **Indemnification.** The final characteristic of insurance is *indemnification* for losses; that is, the reimbursement of the insured if a loss occurs. Within the context of health insurance, indemnification occurs when the insurer pays the insured, or the provider, in whole or in part, for the expenses related to an insured illness or injury. 

**Adverse Selection**

One of the major problems facing insurers is *adverse selection*. Adverse selection occurs because those individuals and firms that are more likely to have claims are more inclined to purchase insurance than those that are less likely to have claims. For example, an otherwise healthy individual without insurance who needs a costly surgical procedure will likely seek health insurance if he or she can afford it, whereas an identical individual without the threat of surgery is much less likely to purchase insurance. Similarly, consider the likelihood of a 20-year old to seek health insurance versus the likelihood of a 60-year old. All else the same, the older individual, with much greater health risk due to age, is more likely to seek insurance.

If this tendency toward adverse selection goes unchecked, a disproportionate number of sick people, or those most likely to become sick, will seek health insurance, and the insurer will experience higher than expected
claims. This increase in claims will trigger a premium increase, which only worsens the problem, because the healthier members of the plan will seek insurance from other firms at a lower cost or may totally forgo insurance. The adverse selection problem exists because of asymmetric information, which occurs when individual buyers of health insurance know more about their health status than do insurers.

Insurance companies attempt to control the adverse selection problem by underwriting provisions. Underwriting refers to the selection and classification of candidates for insurance. From a health insurance perspective, there are two extreme positions that can be taken by insurers regarding underwriting. First, assuming that insurers offer insurance in all 50 states, but not elsewhere, insurers can base premiums on national average statistics without regard to individual characteristics. Thus, each individual (or each individual’s employer, if the firm provides the insurance) would pay the same health insurance premium regardless of age, gender, geographic location, line of work, smoking habits, genetic disposition, and so on. The premium charged for each individual would be sufficient in the aggregate to cover all expected outlays, plus administrative expenses, plus earn a profit for the insurer. In this situation, cross-subsidies clearly exist because young, healthy nonsmokers in relatively safe jobs would pay the same premiums as older, sickly smokers in relatively hazardous jobs. Thus, after taking administrative costs out of the insurance premium, healthy individuals would pay premiums that exceed their expected healthcare costs, while the sicker individuals would pay premiums that are less than their expected costs.

At the other extreme, if no information asymmetries existed and perfect information were available, insurers could charge a premium to each subscriber on the basis of that subscriber’s expected healthcare costs, as was done in the illustration presented previously. Individuals who are expected to have higher costs would be charged higher premiums, and those with lower expected costs would be charged lower premiums. Of course, neither individuals nor insurers has perfect foresight, so the extreme of charging an insured individual on the basis of his or her expected healthcare costs is not actually attainable. However, insurers could take into account all factors that are proven to affect health status, and hence costs, when fixing insurance rates such as smoking habits, weight, cholesterol level, and hereditary factors.

What approach do health insurers take in practice? Initially, most health insurers used community ratings. Here, a single set of premiums, or rates, is offered to all members of a community without regard to age, gender, health status, and so on. Thus, rates reflected geographical differences, and potentially even ethnic and cultural differences if the community was dominated by a single ethnic or cultural group. However, within the community, rates represented an average of high- and low-risk individuals. Then, some insurers (particularly commercial insurers) started to offer experience ratings, whereby rates are set based on the claims experience of the specific group being insured.
For example, the Boeing Company might contract with a health insurer to insure all of Boeing's employees in the Seattle area. If Boeing's employees, who, as a group, tend to be younger and more educated, have lower healthcare costs than the community in general, then insurers competing for the contract that use experience ratings can offer Boeing lower rates than competitors that use community ratings. As more and more employers with low-risk employees seek health insurance based on experience ratings, the least costly groups are skimmed from the insurance pool, and those that remain have higher-than-average costs. Because the healthcare costs for those remaining are above the average for the community, insurers serving that population have no choice but to apply experience ratings, so higher premiums can be charged to the remaining groups. The trend, then, has been toward experience ratings and away from community ratings, although community ratings are still used.

Another way that health insurers protect themselves against adverse selection is by including preexisting conditions clauses in contracts. A preexisting condition is a physical or mental condition of the insured individual that existed prior to the issuance of the policy. A typical clause states that preexisting conditions are not covered until the policy has been in force for some period of time, say, one or two years. Preexisting conditions present a true problem for the health insurance industry. As we discussed previously, one of the key elements of insurance is randomness; that is, payouts on a policy should be in response to random events. If an individual has a preexisting condition, this key feature of insurance is violated. In regards to the preexisting condition, the insurer no longer bears random risk, but rather assumes the role of payer for the treatment of a known condition.

Because of the tendency of insurers to shy away from large predictable claims, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Among other things, the HIPAA sets national standards, which can be modified within limits by the states, regarding what provisions can be included in health insurance policies. For example, under a group health policy, coverage to individuals cannot be denied or limited, nor can individuals be required to pay more, because of health status. Although preexisting condition clauses are not banned, there are limits as to what counts as a preexisting condition and how long it takes for coverage to begin. Also, time credit for preexisting conditions under one plan can be credited toward the exclusion period in a second plan, provided there is no break in coverage. Furthermore, health insurance cannot be canceled because the policyholder becomes sick, and individuals have the right to purchase individual insurance from the insurer that provided group insurance when they leave the firm. All in all, the provisions of the HIPAA give consumers of health insurance protection against arbitrary actions by insurers when health status changes for the worse.

**Moral Hazard**

The fact that insurance is based on the premise that payments are made only for random losses creates the problem of moral hazard. The most common
illustration of moral hazard in a casualty insurance setting is the owner who deliberately sets a failing business on fire to collect the insurance. Moral hazard is also present in health insurance, but its form typically is not so dramatic—not too many people are willing to voluntarily sustain injury or illness for the purpose of collecting health insurance. However, undoubtedly there are people who purposely use healthcare services that are not medically required. For example, some people who live alone might visit a physician or a walk-in clinic for the social value of human companionship rather than to address a medical necessity. Also, some hospital discharges might be delayed for the convenience of the patient rather than for medical purposes. Finally, when the full cost, or most of the cost, is covered by insurance, individuals often are quick to agree to a $1,000 MRI scan or other high-cost procedure that may not be necessary. If the same test required total out-of-pocket payment, individuals would think twice before agreeing to such an expensive procedure unless the medical necessity was clearly understood. All in all, the fact that “somebody else” is paying the costs leads to a greater consumption of healthcare services than would occur if patients bore the costs.

Even more insidious is the impact of insurance on individual behavior. Individuals are less likely to take preventive actions when the costs of not taking those actions will be borne by insurers. Why worry about getting a flu shot if the monetary costs associated with the treatment are borne by the insurer, or why stop smoking if others will pay for the likely adverse health consequences? Clearly, the very fact that insurance exists causes individuals to forgo preventive actions and embrace unhealthy behaviors, both of which might be approached differently in the absence of insurance.

Insurers generally attempt to protect themselves from moral hazard claims by paying less than the full amount of healthcare costs borne by the insured. By making insured individuals bear some of the cost, there will be less of a tendency to consume unneeded services or engage in unhealthy behaviors. One way of doing this is to require a deductible. Medical policies usually contain some dollar amount that must be satisfied before benefits are paid. Although deductibles have some positive effect on the moral hazard problem, their primary purpose is to eliminate the payment of small claims, wherein the administrative cost of processing the claim may be larger than the claim itself. Although there are several types of deductibles, the most common form is the calendar year deductible. Here, the first $100 (or $250 or more) of medical expenses incurred each year is paid by the individual insured. Once the deductible is met, the insurer will pay all eligible medical expenses (less any copayments) for the remainder of the year.

The primary weapon that insurers have against the moral hazard problem is the copayment, which requires insured individuals to pay a certain percentage of eligible medical expenses—say, 20 percent—in excess of the deductible amount. For example, assume that George Maynard, who has employer-provided medical insurance that pays 80 percent of eligible expenses after the $100 deductible is satisfied, incurs $10,000 in medical expenses
during the year. The insurer will pay \( 0.80 \times (\$10,000 - \$100) = 0.80 \times \$9,900 = \$7,920 \), so George’s responsibility is \$10,000 - \$7,920 = \$2,080 \).

The purposes of copayments are to reduce premiums and to prevent overutilization of healthcare services, and hence insurance benefits. Because insured individuals pay part of the cost, premiums can be reduced. Additionally, by being forced to pay some of the costs, insured individuals will presumably seek fewer and more cost-effective treatments and embrace a healthier lifestyle.

Some health insurance policies contain stop-loss limits, also called out-of-pocket maximums, whereby the insurer pays all covered costs, including the copayment, after the insured individual pays a certain amount of copayment costs, say, \$2,000. Thus, if George had \$50,000 of covered expenses above the deductible amount, his coinsurance share would be \$10,000 if there were no stop-loss provision. If his policy contained a stop-loss amount of \$2,000, George would only have to pay \$2,000, and his insurer would pay the remaining \$48,000 of costs. Of course, health insurance policies with stop-loss provisions are more costly than those without such features.

Finally, most insurance policies have policy limits; for example, \$1,000,000 in total lifetime coverage, or \$1,500 per year for mental health benefits, or \$100 for eyeglasses. These limits are designed to control excessive use of certain services and to protect the insurer against catastrophic losses. Of course, a lifetime coverage limit means that subscribers must bear the risk of catastrophic losses.

**Self-Test Questions**

1. Briefly, explain the following characteristics of insurance:
   a. Pooling of losses
   b. Payment only for random losses
   c. Risk transfer
   d. Indemnification
2. What is adverse selection, and how do insurers deal with the problem?
3. What is the moral hazard problem?

**Generic Reimbursement Methods**

Regardless of the payer for a particular healthcare service, only a limited number of payment methods are used to reimburse providers. Payment methods fall into two broad classifications: (1) fee-for-service and (2) capitation. In fee-for-service payment methods, of which many variations exist, the greater the amount of services provided, the higher the amount of reimbursement. Under capitation, a fixed payment is made to providers for each covered life, regardless of the amount of services provided. In this section, the mechanics of alternative payment methods are first considered. The incentives created for providers under the alternative methods are then discussed. Finally, the risk implications of the alternative reimbursement methods are analyzed.
The Methods

The three primary fee-for-service methods of reimbursement are: (1) cost based, (2) charge based, and (3) prospective payment. In addition to the fee-for-service methods, some payers, especially managed care plans, pay by capitation. In this section, the methods are reviewed in more detail.

Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. Reimbursement is limited to allowable costs, usually defined as those costs directly related to the provision of healthcare services. Nevertheless, for all practical purposes, cost-based reimbursement guarantees that a provider's total costs will be covered by payments from payers. Typically, the payer makes periodic interim payments (PIPs) to the provider, and a final reconciliation is made after the contract period expires and all costs have been processed through the provider's accounting system. During the early years (1966–1983), Medicare reimbursed providers on the basis of costs incurred.

When payers pay billed charges, they pay according to the schedule of charge rates established by the provider. To a certain extent, this reimbursement system places payers at the mercy of providers in regards to the cost of healthcare services, especially in markets where competition is limited. In the very early days of health insurance, all payers reimbursed providers on the basis of billed charges. Some insurers still reimburse providers according to billed charges, but the trend for payers is toward other, less generous reimbursement methods. If this trend continues, the only payers that will be expected to pay billed charges are self-pay, or private-pay, patients.

Some payers that historically have reimbursed providers on the basis of billed charges now pay by negotiated, or discounted, charges. This payment method is frequently used by insurers that have established managed care plans such as HMOs and PPOs. Because HMOs and PPOs, as well as some conventional insurers, have bargaining power because of the large number of patients that they bring to a provider, they can negotiate discounts from billed charges. Such discounts generally range from 20 to 30 percent, or more, of billed charges.

In a prospective payment system, the rates paid by payers are determined before the services are provided. Furthermore, payments are not directly related to either reimbursable costs or billed charges. Four common units of payment are included in the category of prospective payment:

2. Per diagnosis. In the per diagnosis reimbursement method, the provider reimburses payers according to the diagnosis of the disease. Diagnoses that
2. **Per diagnosis.** In the *per diagnosis* reimbursement method, the provider is paid a rate that depends on the patient's diagnosis. Diagnoses that require higher resource utilization, and, hence, are more costly to treat, have higher reimbursement rates. Medicare pioneered this basis of payment in its *diagnosis related group* (DRG) system, which it first used for hospital reimbursement in 1983. (Reimbursement on the basis of DRG is discussed in detail in the section on Medicare.)

3. **Per diem (per day).** If reimbursement is based on a *per diem* rate, the provider is paid a fixed amount for each day that service is provided, regardless of the nature of the services. This type of reimbursement is applicable only to inpatient settings. Note that per diem rates can be *stratified*. For example, a hospital may be paid one rate for a medical/surgical day, a higher rate for a critical care unit day, and yet a different rate for an obstetrical day. Stratified per diems recognize that providers incur widely different daily costs for providing different types of care.

4. **Global pricing.** Under *global pricing*, payers pay a single prospective payment that covers all services delivered in a single episode, whether the services are rendered by a single or by multiple providers. For example, a global fee may be set for all obstetric services associated with a pregnancy, including all prenatal and postnatal visits as well as the delivery, provided by a single physician. For another example, a global price may be paid for all physician and hospital services associated with a cardiac bypass operation.

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**Capitation**  
Up to this point, all the reimbursement methods presented have been fee-for-service methods; that is, providers are reimbursed on the basis of the amount of services provided. The service may be defined as a visit, a diagnosis, a hospital day, or in some other manner, but the key feature is that the more services that are performed, the greater the reimbursement amount. *Capitation*, although a form of prospective payment, is an entirely different approach to reimbursement, and hence deserves to be treated as a separate category. Under capitated reimbursement, the provider is paid a fixed amount per covered life per period (usually a month) regardless of the amount of services provided.

Because the payment is tied only indirectly to the amount of services provided, capitation dramatically changes the financial landscape of healthcare providers and, hence, has profound implications for financial management decision making. In fact, we devote a full chapter (Chapter 19) to capitation and its implications.

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**Nonpayment**  
Before we close this section, we think it worthwhile to address briefly the issue of nonpayment. If a user of healthcare services does not have insurance, then the responsibility for payment of total billed charges falls on the patient or
the patient’s family. Because people without health insurance tend to be poor, many of them find it difficult, if not impossible, to pay for healthcare services that can quickly amount to tens of thousands of dollars. Nonpaying patients fall into two categories. First, those who have the capacity, but are unwilling, to pay. The lost revenues attributable to the first class of nonpayer are called bad debt losses. The second group is made up of patients who are not able to pay. The lost revenues attributable to the second class of nonpayer are called charity, or indigent, care losses.

These classifications are important for two reasons. First, the two types of nonpayment are handled differently on the income statement. Second, it is important that not-for-profit providers be able to document their contributions to society, and one of the most important contributions is willingness to treat indigent patients.

**Provider Incentives**

Providers, like individuals and other businesses, react to the incentives created by the financial environment. For example, individuals can deduct mortgage interest from income for tax purposes, but they cannot deduct interest payments on personal loans. Loan companies have responded by offering home equity loans that are a type of second mortgage. The intent is not that such loans would be used to finance home ownership, as the tax laws intended, but rather the funds can be used for any purpose, including financing vacations, cars, and appliances. In this situation, tax laws created incentives for consumers to have mortgage debt rather than personal debt, and the mortgage loan industry responded accordingly.

In the same vein, it is interesting to briefly examine the incentives that alternative reimbursement methods have on provider behavior. Under cost-based reimbursement, providers are given a “blank check” to be used in acquiring assets and incurring operating costs. If payers reimburse providers for all costs, the incentive is to incur costs. Facilities will be lavish and conveniently located, and staff will be available to ensure that patients are given “deluxe” treatment. Furthermore, as in billed-charges reimbursement, services that may not truly be required will be provided because more services lead to higher costs, which mean higher revenues.

Under charge-based reimbursement, providers have the incentive to set high charge rates, which leads to high revenues. However, in competitive markets, there will be a constraint on how high providers can go. But, to the extent that insurers, rather than patients, are footing the bill, there is often considerable leeway in setting charges. Because billed charges is a fee-for-service type of reimbursement, in which more services result in higher revenue, a strong incentive exists to provide the highest possible amount of services. In essence, providers can increase utilization, and hence revenues, by churning—creating more visits, ordering more tests, extending inpatient stays, and so on. Although charge-based reimbursement does encourage providers
to contain costs, the incentive is weak because charges can be more easily increased than costs can be reduced. Note, however, that discounted charge reimbursement places additional pressure on profitability, and hence creates increased incentive for providers to lower costs.

Under prospective payment reimbursement, provider incentives are altered. First, under per procedure reimbursement, the profitability of individual procedures will vary depending on the relationship between the actual costs incurred and the payment for that procedure. Providers, usually physicians, have the incentive to perform procedures that have the highest profit potential. Furthermore, the more procedures the better because each procedure typically generates additional profit. The incentives under per diagnosis reimbursement are similar. Providers, usually hospitals, will seek patients with diagnoses that have the greatest profit potential and discourage (even discontinue) services that have the least profit potential. Furthermore, to the extent that providers have some flexibility in assigning diagnoses to patients, an incentive exists to upcode diagnoses to another one that provides greater reimbursement.

In all prospective payment methods, providers have the incentive to reduce costs because the amount of reimbursement is fixed and independent of the costs actually incurred. When per diem reimbursement is used, particularly with hospitals, providers have an incentive to increase length of stay. Because the early days of a hospitalization are typically more costly to the provider than the later days, the later days are more profitable. However, as mentioned previously, hospitals have the incentive to reduce costs during each day of a patient’s stay.

Under global pricing, providers do not have the opportunity to be reimbursed for a series of separate services, which is called unbundling. For example, a physician’s treatment of a fracture could be bundled, and hence billed as one episode, or it could be unbundled with separate bills submitted for diagnosis, x-rays, setting the fracture, removing the cast, and so on. The rationale for unbundling is usually to provide more detailed records of treatments rendered, but often the result is higher total charges for the parts than would be charged for the entire package. Also, global pricing, when applied to multiple providers for a single episode of care, forces involved providers (e.g., physicians and a hospital) to jointly offer the most cost-effective treatment. Such a joint view of cost containment may be more effective than each provider separately attempting to minimize its treatment costs because lowering costs in one phase of treatment could increase costs in another.

Finally, capitation reimbursement totally changes the playing field by completely reversing the actions that providers must take to ensure financial success. Under all prospective payment methods, the key to provider success is to work harder, increase utilization, and hence increase profits; under capitation, the key to profitability is to work smarter and decrease utilization. As with prospective payment, capitated providers have the incentive to reduce
costs, but now they also have the incentive to reduce utilization. Thus, only those procedures that are truly medically necessary should be performed, and treatment should take place in the lowest cost setting that can provide the appropriate quality of care. Furthermore, providers have the incentive to promote health, rather than just treat illness and injury, because a healthier population consumes fewer healthcare services.

**Financial Risks to Providers**

A key issue facing providers is the impact of various reimbursement methods on financial risk, which is a concept that is explained in detail in Chapters 5 and 13. For now, think of financial risk in terms of the effect that the reimbursement methods have on profit uncertainty—the greater the chances of losing money, the higher the risk. Cost- and charge-based reimbursements are the least risky for providers because payers more or less ensure that costs will be covered, and hence profits will be earned. In cost-based systems, costs are automatically covered. In charge-based systems, providers typically can set charges high enough to ensure that costs are covered, although discounts introduce uncertainty into the reimbursement process.

Regardless of the reimbursement method (except cost based), providers bear the cost-of-service risk in that costs can exceed revenues. However, a primary difference among the reimbursement types is the ability of the provider to influence the revenue/cost ratio. If providers set charge rates for each type of service provided, they can most easily ensure that revenues exceed costs. Furthermore, if providers have the power to set rates above those that would exist in a truly competitive market, charge-based reimbursement could result in higher profits than cost-based reimbursement.

Prospective payment adds a second dimension of risk to reimbursement contracts because the bundle of services needed to treat a particular patient may be more extensive than that assumed in the payment. However, when the prospective payment is made on a per procedure basis, risk is minimal because each procedure will produce its own revenue. When prospective payment is made on a per diagnosis basis, provider risk is increased. If, on average, patients require more intensive treatments, and for inpatients a longer length of stay (LOS) than assumed in the prospective payment amount, the provider must bear the added costs.

When prospective payment is made on a per diem basis, even when stratified, one daily rate usually covers a large number of diagnoses. Because the nature of the services provided could vary widely, both because of varying diagnoses as well as intensity differences within a single diagnosis, the provider bears the risk that costs associated with the services provided on any day exceed the per diem rate. However, patients with complex diagnoses and greater intensity tend to remain hospitalized longer, and per diem reimbursement does differentiate among different LOSs. However, the additional days of stay may be insufficient to make up for the increased resources consumed.
In addition, providers bear the risk that the payer, through utilization review process, will constrain LOS, and hence increase intensity during the days that a patient is hospitalized. Thus, under per diem, compression of services and shortened LOS can put significant pressure on providers’ profitability.

Under global pricing, a more inclusive set of procedures, or providers, are included in one fixed payment. Clearly, the more services that must be rendered for a single payment, or the more providers that have to share a single payment, the more providers are at risk for intensity of services.

Finally, under capitation, providers assume all utilization and actuarial risks along with the risks assumed under the other reimbursement methods. The assumption of utilization risk has traditionally been an insurance, rather than a provider, function. In the traditional fee-for-service system, the financial risk of providing healthcare is shared between purchasers and insurers. Hospitals, physicians, and other providers bear negligible risk because they are paid on the basis of the amount of services provided. Insurers bear short-term risk in that payments to providers in any year can exceed the amount of premiums collected. However, poor profitability by insurers in one year usually can be offset by premium increases to purchasers the next year, so the long-term risk of financing the healthcare system is borne by purchasers. Capitation, however, places the burden of short-term utilization risk on providers.

When provider risk under different reimbursement methods is discussed in this descriptive fashion, an easy conclusion to make is that capitation is by far the riskiest to providers, while cost- and charge-based reimbursement are by far the least risky. Although this conclusion is not a bad starting point for analysis, financial risk is a complex subject, and its surface has just been scratched. One of the key issues throughout the remainder of this text is financial risk, so readers will see this topic over and over. For now, keep in mind that different payers use different reimbursement methods. Thus, providers can face conflicting incentives and differing risk, depending on the predominant method of reimbursement.

In closing, note that all prospective payment methods involve a transfer of risk from insurers to providers, which increases as the payment unit moves from per procedure to capitation. The added risk does not mean that providers should avoid such reimbursement methods; indeed, refusing to accept contracts with prospective payment provisions would be tantamount to organizational suicide for most providers. However, providers must understand the risks involved in prospective payment arrangements, especially the effect on profitability, and make every effort to negotiate a level of payment that is consistent with the risks incurred.

**Self-Test Questions**

1. Briefly, describe the following payment methods:
   a. Cost based
   b. Charge based and discounted charges
   c. Per procedure