A Tale of Two National Health Plans

Learning opportunities in funding public health care

By Chris Pallot and Jennifer Gerstorff

The United Kingdom's National Health Service (NHS) and the United States' Medicaid program were both developed to provide comprehensive health care benefits, with the general goal of finding a balance of quality and efficiency that promotes access to appropriate and financially sustainable medical care. This article lays out the history, current environment and direction of the two systems, including how they parallel.

Background

The NHS and Medicaid both provide publicly funded medical services to a broad population. The NHS offers coverage to all U.K. residents, whereas Medicaid is intended to provide coverage only for certain low-income cohorts of the population who have the greatest need for low-cost care.

FIGURE 1 **NHS AND MEDICAID: COMPARISON OF SPENDING AND COVERAGE**

NHS	Medicaid
£116.4 billion 2015–16 budget	$554.3 billion FFY 2015 spend
54.3 million residents	68.9 million residents

Source: NHS and Department of Health and Human Services

U.K. NHS

The National Health Service was born on July 5, 1948. There have been many changes in its structure and function, but the underlying principle of health care for everyone has remained. Funding is raised through general taxation. The vast majority of primary, secondary, community, mental health and ambulance care is provided without charge at the point of access. Some charges apply for prescribed drugs and dental treatment, but there are exceptions for children, pregnant or immediately post-natal women, seniors or those on low incomes.[1]

The 2015–2016 annual budget for the NHS was £116.4 billion, and it is expected to rise to £133.1 billion by 2020–2021. Much of this will be needed to fund inflation, leaving a real terms increase of circa £11 billion, a real annual increase of 0.9 percent.[2]

The NHS is seen as one of the most important political issues in the United Kingdom, often attracting both positive and negative media interest.

U.S. Medicaid

Medicaid was established July 31, 1965, with an amendment to the Social Security Act (SSA).[3] Medicaid covers low-income children, pregnant women and disabled citizens, and provides comprehensive benefits, as outlined by the Centers for Medicare & Medicaid Services (CMS). Each state must offer certain mandatory services; all states offer the optional prescription drug coverage, and other optional service coverage varies by state.

U.S. health care is a main focus in the political arena, as expenditures continue to rise as a percentage of gross domestic product (GDP), growing to 17.5 percent in 2014, or more than $3 trillion. Medicaid made up approximately 16 percent of U.S. health care spending, or a half-trillion dollars, in 2014, doubling in total expenditure amounts since 2002.[4]

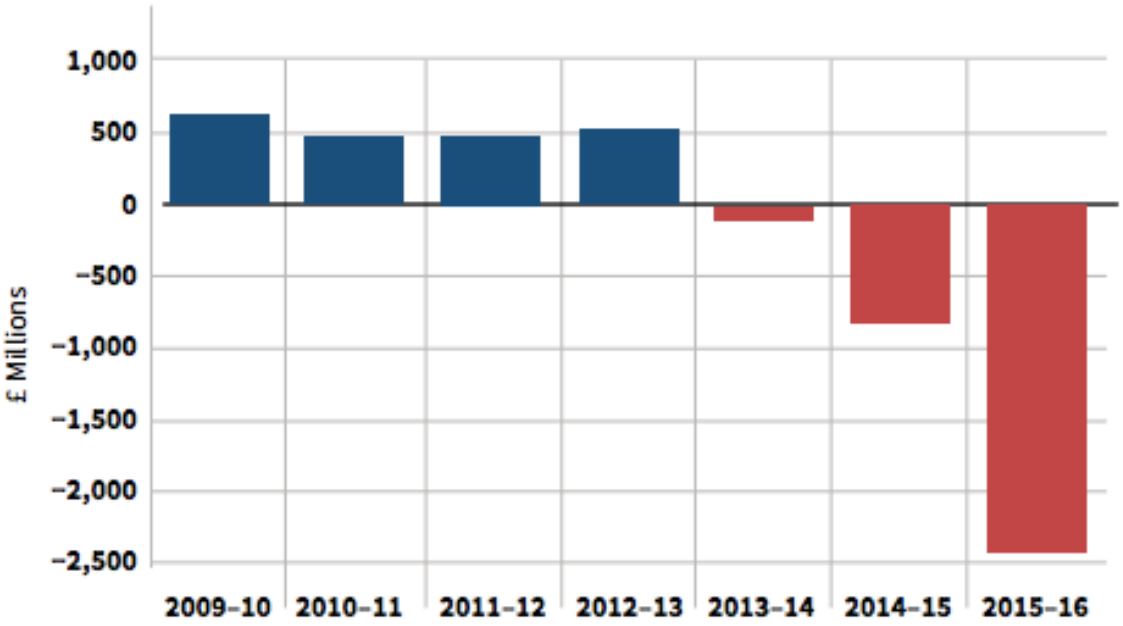
Funding

In both systems, health care expenditures have been rising faster than GDP since the 1990s,[5] making it difficult for funding to keep pace.

U.K. NHS

The funding for the NHS is decided by Parliament each year, and then allocated to the Department of Health. For 2016–2017, this is £120.4 billion. The issue for the NHS is its ability to live within this allocation, and the increasing deficits that its medical providers are facing. The financial problems within the NHS are well documented; the provider sector (excluding payers) finished the last financial year with a deficit of circa £2.4 billion—which is the highest level ever observed.

FIGURE 2 NHS TRUSTS, END-OF-YEAR FINANCIAL RESULTS



Source: NHS Improvement

The NHS is responding with new planning and is seeking to integrate care on an unprecedented scale. There is a desire to incorporate pay-for-performance mechanisms, a point where the U.K. and U.S. systems can learn from each other.

U.S. Medicaid

Medicaid is a jointly funded federal/state partnership. Unlike the NHS, annual budgets vary based upon population size and utilization, although a block grant system has been proposed. When states follow federal program guidelines, they receive federal contributions somewhere between 50 percent and 75 percent of traditional Medicaid service cost (as of federal fiscal year 2017).[6] This amount is updated each year and is based on a formula that compares average state per capita income with the national average.

Medicaid's primary funding source comes from federal and state taxation, but also includes other sources, such as taxes on Medicaid providers or upper payment limit (UPL) payments. Payments from Medicaid enrollees are a marginal source of funding, as premiums and cost sharing are limited by law. It is standard, however, for Medicaid beneficiaries who require long-term care services, such as residents of custodial care nursing facilities, to contribute a significant portion of their monthly incomes toward the cost.

Contracting

For the NHS and Medicaid, government entities contract directly with medical providers on either a national or local level. Payment rates are also set by government entities, though in the United Kingdom this is done at a national level and in the United States it is performed by each state. The levels of reimbursement also differ considerably between the United States and the United Kingdom, as illustrated in **Figure 3**.

FIGURE 3 LEVELS OF REIMBURSEMENT

Procedure	NHS Tariff	Medicaid (Low)	Medicaid (High)	Medicare Fee
Carpal tunnel surgery	£865 / $1,211	£668 / $935	£1,078 / $1,509	£1,191 / $1,668
Cataract surgery	£982 / $1,375	£647 / $906	£1,233 / $1,726	£1,454 / $2,036
Varicose vein surgery	£1,113 / $1,558	£624 / $874	£1,224 / $1,713	£1,266 / $1,773
Prenatal, delivery and postpartum care	£4,120 / $5,768	£2,600 / $3,640	£3,753 / $5,254	N/A

Notes: Exchange rate of £1:$1.40 was used for conversion (pre-Brexit rates).
Source of NHS Tariffs: *https://www.england.nhs.uk/nhs-standard-contract/16-17.*
Source of Medicaid range of fees is an informal survey among state and health plan actuaries who work in Medicaid, representing multiple states.
Source of Medicare fees is the national average from the calendar year (CY) 2015 CMS 5 Percent Sample claims database.

U.K. NHS

Each general hospital typically will hold two key contracts with its payers, for the provision of clinical services. One is for the provision of general services, which make up the vast majority. The second is for treatments that are considered specialist in nature and are paid for at a regional or national level by NHS England.[7] The principle is that the whole hospital sector is contracted on the same basis, using a payment mechanism that is identical except for some fluctuation to account for differing input costs, such as salary costs in urban centers versus rural areas.

U.S. Medicaid

Unlike the NHS national tariff, each state works with local providers to develop fee schedules. Even within a state, the reimbursement will likely vary from provider to provider. This is most clearly the case with safety net providers, local organizations that serve uninsured and other low-income populations. Medicaid reimbursement is well-known in the United States to be far lower than commercial or Medicare fees. Medicaid also has hired managed care organizations (MCOs) to educate Medicaid members on service use and guide better utilization practices than a fee-for-service (FFS) delivery system. MCOs have been increasing their presence over the recent decades, and now more than 80 percent of enrollees receive benefits through managed care.[8]

Innovations

U.K. NHS

New models of care are emerging in the NHS similar to Medicaid's MCOs, with the aim being to integrate provision, reducing barriers between health sectors and increasing efficiencies. This strategy is one of the key strands of the Five Year Forward View.[9] Two aspects of the NHS Standard Contract offer strong incentives to providers. The first is the requirement to comply with minimum access standards (waiting times) for treatment, with noncompliance attracting considerable fines and penalties. In some instances, the penalties exceed the income for that particular intervention.

The second key area is the use of value-based reimbursement metrics. For the past few years, the contract has included Commissioning for Quality and Innovation metrics, referred to as "CQUIN schemes." They provide the opportunity for providers to earn an additional 2.5 percent of their annual contract values. Some schemes are nationally mandated, and others can be agreed locally.

In primary care, the Quality and Outcomes Framework is a well-established mechanism to incentivize the delivery of services that improve overall health and increase efficiencies.[10]

U.S. Medicaid

Several initiatives have been made in Medicaid to achieve savings over the years, including the pharmacy rebate program; employer-sponsored insurance premium assistance; aggressive pursuit of waste, fraud and abuse; holding fee schedules at low or flat rates each year; and care management models. The most widespread savings instrument has been the shift to delivery of benefits under managed care. However, now that a majority of Medicaid

beneficiaries are enrolled in managed care, states and CMS are trying to determine where to go next.

In addition to expanding eligibility criteria, the ACA also amended the SSA to establish the CMS Innovation Center. The goals of the Innovation Center are to test new payment and service delivery models, evaluate and advance best practices, and engage stakeholders to develop new test models.[11] There are seven Innovation Models that can be pursued: accountable care; episode- based payment initiatives; primary care transformation; and initiatives focused on the Medicaid and CHIP populations, Medicare-Medicaid enrollees, testing new payment and service delivery models; and best practices.

Summary: Compare, Contrast and Outlook

Drawing the previous sections together, we can observe many similarities:

- The overarching principles of the Triple Aim are featured in key NHS strategy documents, such as the Five Year Forward View.
- Medical expenditures have been growing faster than the GDP.
- Cost sharing is limited for most benefits and population groups.
- The majority of hospital services are funded on a FFS basis.
- Funding discussions are widespread in the news and are a key platform for political debate.
- Contracts are developed between government entities and medical providers (which may be government-owned or private sector providers).
- Government entities are responsible for setting reimbursement amounts paid for medical services.
- Development of innovative ways to improve quality outcomes and reduce cost are crucial to future sustainability.
- Several model categories are currently being tested in both countries. In the United Kingdom, a range of models is being piloted in "vanguard" organizations, with the view of rolling them out across the United Kingdom. Full details can be found in the Five Year Forward View.

We also observe differences:

- The NHS is responsible for the national population, while Medicaid is responsible for primarily low-income individuals.
- Eligibility for services in the NHS is consistent nationally, as listed in the NHS Constitution with minor variations by some local payers, while eligibility requirements for Medicaid vary state by state.
- The NHS covers one package of benefits for all citizens, while Medicaid has flexibility to modify benefits to include or exclude optional services, which creates varied benefits by state.
- The NHS is appropriated a fixed lump sum by Parliament regardless of population size, while Medicaid funding may vary based on population size and individual state budgets.

- The NHS is funded by the central government, while Medicaid is funded jointly by national and state governments.
- The NHS sets a national tariff for medical services, while Medicaid fee schedules vary by state and provider.
- While delivery of care through managed care integrators is relatively new with the NHS, Medicaid has been using managed care organizations for decades.

One thing is for sure: There is much for both systems to learn from each other. Health is definitely an area where the special relationship between the two countries could lead to exciting developments that could benefit several millions of patients.

Chris Pallot, MSc, BA (Hons), DipM, Dip HSM, is director of Strategy & Partnerships at Northampton General Hospital in the United Kingdom. ***chris.pallot@ngh.nhs.uk***

Jennifer L. Gerstorff, FSA, MAAA, is a consulting actuary with Milliman's Seattle health practice. She is a member of the SOA Health Council and currently leads the health council's Medicaid subgroup.
jennifer.gerstorff@milliman.com

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