Commentary Article

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LESSON LEARNED FROM THE UNITED STATES: IMPROVING HEALTH COVERAGE IN A PRIMARY CARE

Pelajaran dari Amerika Serikat: Meningkatkan Jaminan Kesehatan di Layanan Primer

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Abstract

The universal health coverage in Indonesia is organized by *Badan Penyelenggara Jaminan Kesehatan* (BPJS), which gives health protection to the population as in medical insurance. This health coverage is essential to protect and maintain the quality of health in the Indonesian population. However, there were some burdens for universal health coverage, including the accessibility to National Health Insurance (JKN). Therefore, we may learn about improving health coverage in the United States, which is well known for Medicare and Medicaid, —the center of the US medical insurance. There are at least three main lessons to learn from medical insurance in the US, such as enrollment for medical insurance, sliding fee discount program, and cost analysis for fee-for-service in health care. Despite the difference in health system and population between the United States and Indonesia, these lessons could be tailored to reduce the burden to the universal health coverage in Indonesia.

Keywords: cost analysis, medical insurance, sliding fee discount, universal health coverage

Abstrak

Jaminan kesehatan semesta di Indonesia dikelola oleh Badan Penyelenggara Jaminan Kesehatan (BPJS) yang memberikan perlindungan kesehatan kepada masyarakat dalam bentuk asuransi kesehatan. Jaminan kesehatan merupakan hal esensial untuk melindungi dan menjaga kualitas kesehatan masyarakat Indonesia. Namun masih terdapat hambatan untuk pencapaian jaminan kesehatan semesta tersebut, seperti akses untuk mendapatkan Jaminan Kesehatan Nasional (JKN). Oleh karena itu, kita dapat belajar meningkatkan perlindungan kesehatan ini dari Amerika Serikat yang dikenal memiliki Medicare dan Medicaid, — asuransi kesehatan utama di Amerika Serikat. Terdapat tiga hal yang dapat kita pelajari dari asuransi kesehatan di Amerika Serikat, seperti kemudahan akses mendapatkan asuransi kesehatan, program discount biaya kesehatan, dan analisis biaya untuk fee-for-service dalam suatu fasilitas kesehatan. Walaupun terdapat perbedaan dalam sistem kesehatan dan kondisi masyarakat antara Amerika Serikat dan Indonesia, ketiga pelajaran ini dapat diadaptasikan untuk meminimalisasi hambatan dalam mencapai jaminan kesehatan semesta di Indonesia.

***Kata kunci**: analisis biaya, asuransi kesehatan, program discount biaya kesehatan, jaminan kesehatan semesta*

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Introduction

The universal health coverage in Indonesia is organized by Badan Penyelenggara Jaminan Kesehatan (BPJS) which gives a health protection to the population as medical insurances. This universal health coverage is called National Health Insurance, known as *Jaminan Kesehatan Nasional* (JKN).

JKN is a national health coverage for Indonesian people with a concept of social insurance and equity based in medical indication (Ministry of Health, 2014). The implementation of JKN is protecting the health of population through a medical insurance, including own paid premium (Non PBI) and premium paid by the government (PBI). The concept of JKN is adapted from the Managed Care which consists of family medicine, referral system, and prospective payment system. Although it adapts the Managed Care, but it lacks of cost control which resulted as deficit in the BPJS. Moreover, there are still some people have not enrolled yet to the JKN. Therefore, we need to learn from the United States (US) health insurance system to address those problems, including enrollment for medical insurance, sliding fee discount program, and cost analysis for fee-for-service in a primary health care.

Discussion

Enrollment for Medical Insurance

People who live in the United Stated should enroll for medical insurances to ensure they have protection for health issues. Having medical insurances are more beneficial than paying out-of-pocket regarding the expensive cost of medical services in the US (Finkler *et al.*, 2018; Zietlow *et al.*, 2018). Compared to Indonesia where majority of people still have burden to enroll into JKN, the enrollment for medical insurance is accessible to all residents in the US. They can enroll themselves online through a federal website called Health Insurance Marketplace (https://www.healthcare.gov). From this website, they could consider any healthcare plan that is available in their states and suits their needs. The information of monthly premium, deductible, co-pay, co-insurance, and out-of-pocket maximum are easily accessed from this website (Figure 1). It also gives comparation of benefits between each healthcare plan. Therefore, people can choose the healthcare plan that suit their needs and also enrolled themselves to the health insurance without hassle.

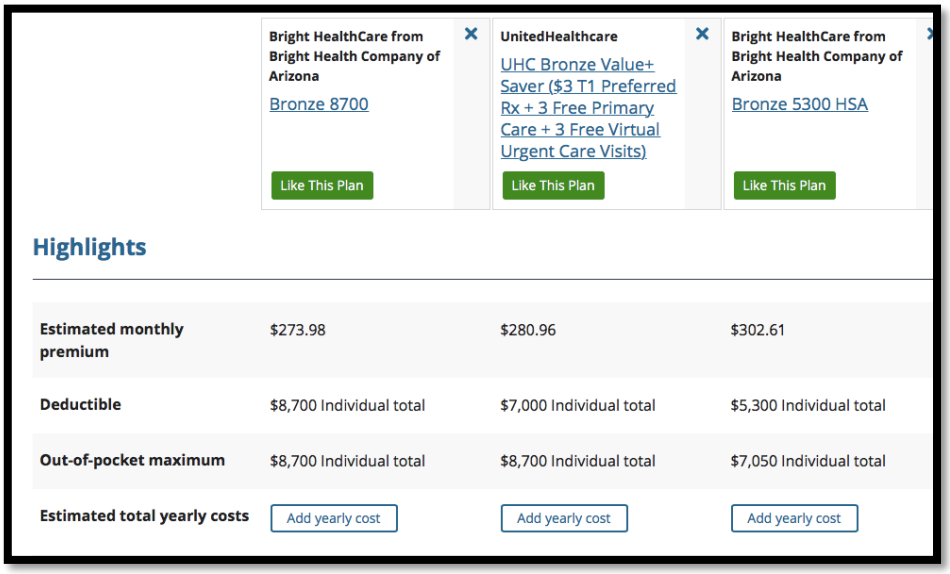

Figure 1. Comparison of Healthcare Plan from the Healthcare.gov (Department of Health, 2022)

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Table1. Sliding Fee Scale Discount Program (Effective: July 1st, 2021)

Services	Medical Cost					
	Code 0	Code 1	Code 2	Code 3	Code 4	Code 5
Primary Care Medical Service						
Administrative fee – Primary Care Office Visit	$40	$45	$50	$55	Full price	Full price
Administrative fee – Primary Care Office Visit. with Procedures, Injection, and/or Labs (exclude specialty labs)	$70	$80	$90	$100	Full price	Full price
Obstetrics Prenatal Plan	$475	$525	$575	$600	Full price	Full price
Gynaecologist – In House (Colposcopy and LEEP)	$375	$425	$475	$500	Full price	Full price
Circumcision	$200	$250	$275	$325	Full price	Full price
Vasectomy	$375	$475	$575	$675	Full price	Full price
Dermatology Office Visit	$55	$60	$65	$70	Full price	Full price
Dermatology Office Visit with In-House Procedure	$110	$115	$120	$125	Full price	Full price
Podiatry General Visit	$55	$60	$65	$70	Full price	Full price
Podiatry General Visit with In-House Procedure	$110	$115	$120	$125	Full price	Full price
Family Planning Services (Title X Medicare)						
Administrative fee – Family Planning Office Visit (includes lab fees and supplies)	0	$30	$35	$45	$50	Full price
Laboratory Services						
Administrative fee – Labs and/or injections (excluding specialty labs)	$35	$40	$45	$50	Full price	Full price
Specialty care laboratory at cost	*See Sonora Quest Laboratories Fee Schedule*					
INR	$10	$10	$10	$10	Full price	Full price
TB Skin test	$30	$30	$30	$30	Full price	Full price
Immunization (including Flu)	*Immunization may be covered by Department of Health Services or may vary by insurance plan*					
Administration of immunization 1 only	$20	$20	$20	$20	Full price	Full price
Administration of immunization 2 only	$40	$40	$40	$40	Full price	Full price
Behavioral Health Services						
Counseling – Initial Assessment	$40	$45	$50	$55	Full price	Full price
Counseling – Re-Assessment Follow-up	$25	$30	$35	$40	Full price	Full price
Counseling – Individual Intervention	$25	$30	$35	$40	Full price	Full price
Counseling – Group Intervention	$5	$7	$9	$11	Full price	Full price
Counseling – Family session with patient	$25	$30	$35	$40	Full price	Full price
Counseling – Family session without patient	$35	$40	$45	$50	Full price	Full price

Source: Bureau of Primary Health Care (2018)

Table 2. Federal Poverty Income (Annual Income)*

Family Size	Code 0 Under 100%	Code 1 101% to 125%	Code 2 126% to 150%	Code 3 151% to 200%	Code 4 201% to 250%	Code 5 Over 250%
1	13,590	13,591 - 16,591	16,592 - 19,592	19,592 - 25,500	25,501 - 31,150	31,151 and up
2	17,590	17,591 - 21,591	20,301 - 24,360	24,361 - 32,361	32,362 - 40,600	40,601 and up
3	21,590	21,591 - 26,591	25,526 - 30,630	30,631 - 40,840	40,841 - 50,050	50,051 and up
4	25,600	25,601 - 32,750	30,751 - 36,900	36,900 - 50,200	50,201 - 62,500	62,501 and up
5	29,600	29,601 - 37,975	35,976 - 43,170	43,171 - 57,560	57,561 - 71,950	71,951 and up
6	33,600	33,601 - 41,200	41,201 - 49,440	49,441 - 63,020	63,021 - 79,400	79,401 and up
7	37,600	37,601 - 46,425	46,426 - 55,710	55,711 - 71,280	71,281 - 89,850	89,851 and up
8**	41,600	41,601 - 51,650	51,651 - 61,980	61,981 - 79,640	79,641 - 99,300	99,301 and up

*Source: (Health and Human Services Department, 2022)
**For families/ households with more than 8 persons, add $4180 for each additional person.

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Furthermore, people with income at or below 200% Family Poverty Level (FPL) will be assessed by the website whether they are eligible for the Federal Insurance Program, such as Medicare and Medicaid. If the annual family income is 200% lower than the Family Poverty Level, then this family is eligible for Medicare and Medicaid which depends on the condition of the family member (elderly, children, or disability). Lopez et. al (2020) assessing this classification of Medicare with literature review method which is resulted that there are variety of Medicare class regarding geographic adjustment, household expenditures, and disproportionate share hospital (Lopez *et al.*, 2020).

Sliding Fee Scale Discount Program

One of the issues for low-income and uninsured population in the US was the financial barrier to access health services. Sliding fee discount program (SFDP) is intended to minimize this barrier for those population whose income at or below 200% Family Poverty Level (Bureau of Primary Health Care, 2018). This sliding fee discount program has been applied to all patients for all in-scope services provided in a primary health care (Bustamante and Felix-Beltran, 2020).

Regarding the SFDP program, there are 4 discount pay classes based on income and family size, —as defined by the Governing Board in the primary health care. The SFDP were classified into Code 0 (100% FPL and below), Code 1 (101-125% FPL), Code 2 (126-150% FPL), Code 3 (151-200% FPL), Code 4 (200-250% FPL), and Code 5 (above 250% FPL) (Table 2). These codes represented how much the discount rate to pay for medical services (Table 1). For examples, the charge on primary care office visit in Code 0 was $35, while in Code 1 was $40, Code 2 is $45, Code 3 was $50, Code 4 and Code 5 paid a full service. This charge was gradient based on the income class which has been reviewed by the Governing Board before it is declared to patients (Shank and Riley, 2020).

From the Table 2, it is shown that a family size of 1 with annual income under 100% FPL is defined as Code 0. Therefore when this person has a medical service, he/she would only pay $35 instead of $150 for one visit (Bureau of Primary Health Care, 2018). Moreover, this person might still have a chance to enroll in a health insurance plan. Once this person is enrolled to a health insurance, the $35 cost is reimbursed to him/her (Bustamante and Felix-Beltran, 2020). Regarding this situation, SFDP is valuable to minimize burden to access health care for the low-income or uninsured population (Shank and Riley, 2020).

Cost Analysis

To have an accurate fee-for-service for the given medical services, the Bureau of Primary Health Care gives guidance for the primary care to analyze the medical cost, which is called a Physician Fee Schedule. Physician Fee Schedule (PFS) is a list of fee-for-services given by a physician based on the medical service in a health care (Centers for Medicare and Medicaid Services, 2021, 2022). This PFS shows the payment rate for each individual services given by a health care based which might different between one health care to another. Different location of health care might use more expensive resources, therefore the medical cost should first be analyzed to get a valid and reasonable rate (Finkler *et al.*, 2018; Centers for Medicare and Medicaid Services, 2022). Furthermore, this PFS could minimize the risk of deficit in the financial balance of a health care.

The payment rate is calculated by multiplying each Relative Value Unit (RVU) with each Geographic Practice Cost Index (GPCI). Relative Value Unit (RVU) is a relative unit of time, skill, training and intensity required for a physician to provide medical service (Centers for Medicare and Medicaid Services, 2021). It is designed by the Centers for Medicare and Medicaid (CMS) to compare the weight of services and procedures. RVU consists of work RVU, overhead RVU and malpractice RVU (Centers for Medicare and Medicaid Services, 2018, 2021). Work RVU is the relative time and intensity associated with

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providing a Medicare service. Overhead RVU represents the costs to maintain a medical practice, including staff cost, renting of buildings, buying supplies and equipment. Malpractice RVU defines the cost of malpractice insurance (Centers for Medicare and Medicaid Services, 2018, 2021). Malpractice RVU is a safety net if the given medical services will bring any malpractice issues in the future. In addition, Geographic Practice Cost Index (GPCI) determines the allowable payment amount for medical services which is adjusted by different rates in wages and overhead costs across a geographic region in the US. GPCI is calculated based on the location of a health care (Centers for Medicare and Medicaid Services, 2021).

Before calculating the PFS, we should classified all medical services based on their Current Procedural Terminology (CPT) codes. Number of encounters and current charges are defined by CPT codes. Current Procedural Terminology (CPT) code is a medical code used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance providers, and accreditation organizations (Centers for Medicare and Medicaid Services, 2022). After listing all CPT codes in the primary care setting, we calculated the annual expenses which include direct and indirect costs.

After we have the CPT code, we multiplied each RVU (work RVU, overhead RVU and malpractice RVU) with the Geographic Practice Cost Index (GPCI) to get adjusted RVU (Centers for Medicare and Medicaid Services, 2018). Each of these adjusted RVUs were summed up to get the RVU per CPT codes.

Any encounters for each medical service are multiplied by the RVU per CPT code to get the Total RVU. In addition, the annual expenses are divided by the total RVU to get the Average Cost per RVU. Finally, the fees for every service was calculated from the RVU per CPT codes multiplied by the Average Cost per RVU. The final calculation of fees was compared with the 50th and 75th percentiles of the Usual, Reasonable, and Customary (UCR) Medical Fees posted by the PMIC (Practice Management Corporation). The calculation of PFS should not too high or too low from the usual medical fees in similar location (Anagnostopoulou and Stavropoulou, 2021) . The reasonable costs were posted as the Physician Fee Schedule.

To claim reimbursement for the government insurance program, such as Medicare services, the charge of service is taken from the Physician Fee Schedule (Eltorai *et al.*, 2018). Every claim was reported as G-code, including G0466 for a new medical visit, G0467 for an established medical visit, G0468 for an Initial Preventive Physical Exams and Annual Wellness Visits, G0469 for a new behavioral health visit and G0470 for an established behavioral health visit (Centers for Medicare and Medicaid Services, 2022). G-codes are a set of specific payment code used to claim reimbursement from Medicare (Centers for Medicare and Medicaid Services, 2021, 2022). Referring the reimbursement charge to PFS could minimize the risk of claim refusal by the government, as in Medicare program.

In conclusion, cost analysis is a valuable tool to maximize payments from insurance providers and to review managed care contracts to determine if payments are fair and reasonable (Nolan *et al.*, 2014; Finkler *et al.*, 2018).

Learning from three main lessons in the US medical insurance, Indonesia can adapt those lessons to the National Health Insurance (JKN). Regarding the digitalization in Healthcare (Healthcare 4.0) nowadays, the benefits and health plan of each class in JKN can be informed in the JKN mobile application. Therefore, those people who pay the insurance premium by themselves (Non PBI) can consider which classes should be chosen. For example, the middle-income people can choose the first class of JKN if they agree with the health plan although their annual income are more suitable to the second class. Moreover, the suitable health plan should be synchronized with the tax system, therefore the low-income people will be automatically paid by the government (PBI) without administration nuisance.

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There is another way to give health protection to those uninsured people, especially low-income population. The low-income people sometimes abandon their symptoms and do not immediately seek health care because they could not afford medical cost. These uninsured people can be offered with Sliding Fee Scale Discount program before they enroll to the JKN. Paying for medical care with a discount rate is more affordable than paying for medical care on a regular fare. Moreover, once these people are eligible to enroll for JKN, the prior payment they made can be reimbursed. Therefore, the health facilities have a safety net from the discount rate payment which can be claimed as soon as the people get insured. This sliding fee scale discount program gives benefits to both the uninsured patient and healthcare facilities.

Moreover, one issue of fee-for-service payment from BPJS to the hospital is unclaimed treatment and procedures. Sometimes the cost of medical care which is claimed by the hospital could not be verified by BPJS. If the medical cost is assessed as too expensive than the budget, then the BPJS would not verify the claim. This will bring a deficit to the hospital. Therefore, the medical cost should first do a Cost Analysis to have a reasonable list of prices regarding variation in types of physicians (primary care or specialist), types of medicine, types of medical equipment, the operational cost (electricity, water, etc), and variety of location. Furthermore, the Cost Analysis also includes a safety net if the given medical services will bring any malpractice issues in the future.

Conclusion

Reducing barrier to universal health coverage can be approached from financial management in a health care. There are at least three main lessons to learn from the medical insurance in the US, such as enrollment for medical insurance, sliding fee discount program, and cost analysis for fee-for-service in a health care. We can learn from the US the importance of Sliding Fee Discount Program and Cost Analysis to minimize the burden for low-income and uninsured population to access health care. Furthermore, the enrollment for medical insurance is accessible for all population through a website. Despite the difference of health system and population between the United States and Indonesia, these lessons could be tailored for reducing burden to universal health coverage in Indonesia

Abbreviations

US: United States, FPL: Family Poverty Level, SFDP: Sliding Fee Discount Program, PFS: Physician Fee Schedule, RVU: Relative Value Unit (RVU), GPCI: Geographic Practice Cost Index, CMS: Centers for Medicare and Medicaid, CPT: Current Procedural Terminology, UCR: Usual, Reasonable, and Customary, PMIC: Practice Management Corporation.

Declarations

Ethics Approval and Consent Participant
Not applicable.

Conflict of Interest
The authors declare that there is no significant conflict of interest that might have affected the performance.

Availability of Data and Materialss
Not applicable.

Authors' Contribution
Synthesized (KTK, LGP, DCO), drafted (KTK, GPB), and revised the manuscript (KTK, DCO).

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References

Anagnostopoulou, S.C. and Stavropoulou, C. (2021) 'Earnings management in public healthcare organizations: the case of the English NHS hospitals', *Public Money \& Management*, pp. 1–10.

Bureau of Primary Health Care (2018) *Sliding Fee Discount Program*, *Health Resources and Services Administration*. Available at: https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol/sliding-fee-discount.

Bustamante, A. and Felix-Beltran, L. (2020) 'How to expand health care coverage to undocumented immigrants: a policy toolkit for state and local governments'.

Centers for Medicare and Medicaid Services (2018) *Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System*, *Medicare Learning Networks*.

Centers for Medicare and Medicaid Services (2021) *Medicare Physician Fee Schedule*, *Medicare Learning Networks*.

Centers for Medicare and Medicaid Services (2022) *Medicare Claims Processing Manual: Chapter 12 - Physicians/Nonphysician Practitioners*, *Medicare Learning Networks*.

Department of Health (2022) *Get Coverage*, *Health Insurance Marketplace*. Available at: https://www.healthcare.gov.

Eltorai, A.E.M. *et al.* (2018) 'Trends in Medicare reimbursement for orthopedic procedures: 2000 to 2016', *Orthopedics*, 41(2), pp. 95–102.

Finkler, S. A. *et al.* (2018) *Financial management for public, health,and not-for-profit organizations*. 6th edn. United States: SAGE Publications, Inc.

Health and Human Services Department (2022) 'Annual Update of the HHS Poverty Guidelines'. Department of Health and Human Services. Available at: https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines.

Lopez, E. *et al.* (2020) 'How much more than Medicare do private insurers pay? A review of the literature', *Kaiser Family Foundation: Medicare. https://www. kff. org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/. Published* [Preprint].

Nolan, L. *et al.* (2014) *An Assessment of the Safety Net in Phoenix, Arizona*. Washington DC.

Shank, C. and Riley, B. (2020) 'A Stronger Safety Net: Community Health Centers 10 Years After the Affordable Care Act', *North Carolina Medical Journal*, 81(6), pp. 394–397.

Zietlow, J. *et al.* (2018) *Financial management for nonprofit organizations: policies and practices*. John Wiley & Sons.