



# Exploring • Health • Issues

## **Health Care Reform: An Introduction to the Issues**

### **PART I.**

### **Introduction**

Everyone everywhere is talking about health care reform. It is an issue on both state and national agendas. Many facts are offered to demonstrate why we need health care reform, and many ideas are offered on how to design and implement a better health care system. But often what we hear is confusing, and sometimes what we hear is contradictory. Some people use jargon we do not understand, while others argue for specific agendas they want to see enacted. Both of these situations can lead to confusion and an incomplete understanding of the issues.

This publication will provide a brief overview of the health care system today and highlight the key characteristics of current proposals for health care reform.

### **The Current Health Care Situation**

America spends more per person on health care than any other nation and has the most advanced medical technology in the world. Yet, by many measures, we are less healthy than people in many other countries. We are 15th in life expectancy, 22nd in infant mortality (the proportion of infants who die within the first year after birth), and 21st in childhood mortality (the proportion of infants who die within the first five years of life). Even the most basic health services — childhood immunizations, treatment for infections and preventive care — are beyond the reach of many Americans. In 1987, the percentage of fully immunized children in the U.S. was less than one-half the percentage in Britain, Canada, Spain, France, Sweden, and Israel.

In the late 1980s, one in every four pregnant women in the U.S. received no medical care during the crucial first three months of pregnancy, and without prenatal care in the first trimester, a

mother is three to six times more likely to have a premature, low-birth-weight baby. For millions of Americans, the local hospital's emergency room is the first line of health care.

Quite simply, access to health care is increasingly a privilege that fewer and fewer Americans enjoy.

### **The Problems with Today's Health Care System**

When the issue of health care is discussed, the main problems identified are the soaring costs of health care, the growing number of Americans with no health insurance or with inadequate health insurance, and limited access to health care services. These both explain what is wrong with our current approach to providing health care services to all Americans and highlight possible areas for reform.

# Soaring Costs of Health Care

Soaring health care costs are battering the budgets of families, businesses, and state and federal governments. The U.S. spends far more per person on health care than any other country. We spend 13% of our Gross National Product (GNP), or \$817 billion, compared to 8.9% spent by our northern neighbor Canada. Yet in 1971, when Canada fully implemented its national health care system, both countries were spending about 7.4% of their GNPs on health care.

In 1991, U.S. spending on health

care averaged \$6,535 per family. Two-thirds of these costs were paid for by families; the other third was covered by businesses. But in Kentucky, it is estimated that families paid nearly 71 cents of every dollar spent for health care, while businesses paid nearly 30 cents (Figure 1).

What does this mean for the average family? American families directly paid \$4,296 for health care in 1991. This represented 14.2% of the average family's income. Kentucky families are estimated to spend \$3,206 or 11.7% of their average family income for health care (Figure 2).

Even more significant is what will

happen if we simply continue on without change. If we make no changes, by the year 2000 health care costs will absorb 16.4% of the average family's income.

## How Health Care Dollars Are Spent

### By Families

Overall, Kentucky's families have seen their health care bill increase 110% during the 1980s, while businesses have had to deal with a 221% increase in their health care costs (Figure 3).

Nationally, the biggest share of the family health care dollar (nearly 40 cents) is spent through general taxes which are used to provide a variety of health care services. Direct out-of-pocket expenditures for health care average 32 cents of every family health care dollar. Insurance premiums account for about 17 cents of that family health care dollar, and Medicare payroll taxes and premiums account for 11 cents.

Kentucky families spend their health care dollars in a slightly different way. General taxes represent nearly 41 cents; direct out-of-pocket costs are just over 34 cents; insurance premiums are nearly 14 cents; and Medicare payroll taxes and premiums are 11 cents (Figure 4). Over the last decade in Kentucky, the average family spent less in direct out-of-pocket costs, but more in general taxes and Medicare for health care (Figure 5).

### By Business

On average, business spending for employees' health care exceeds 50% of pre-tax profits. This amount is compared to only nine percent in 1965. Employee health insurance costs

## Who Pays the National Health Care Bill?

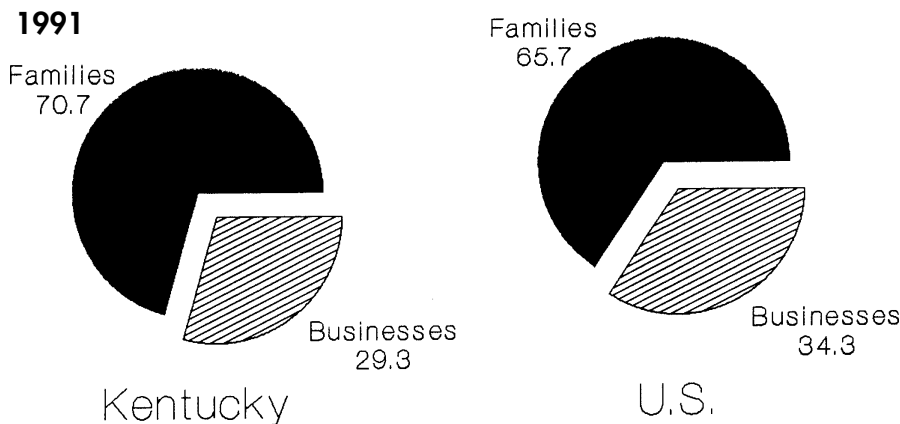


figure 1.

## What Proportion of Average Family Income in Kentucky Goes to Pay for Health Care?

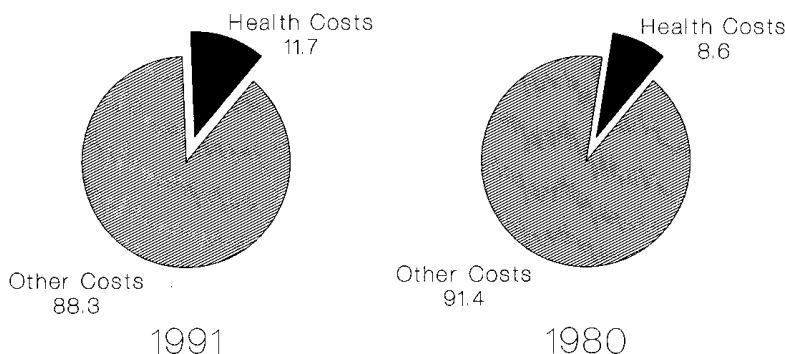


figure 2.

## Change in Cost of Health Care in Kentucky: 1980 - 1991

FAMILIES	+110%
BUSINESSES	+221%

figure 3.

## Where Does the Family Health Care Dollar Go?

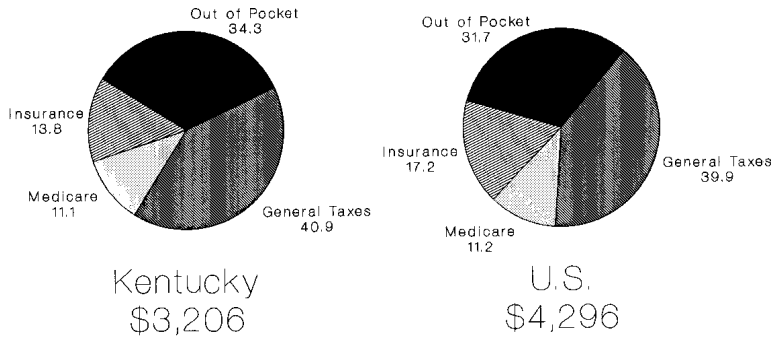


figure 4.

## How is the Kentucky Family Health Care Dollar Spent?

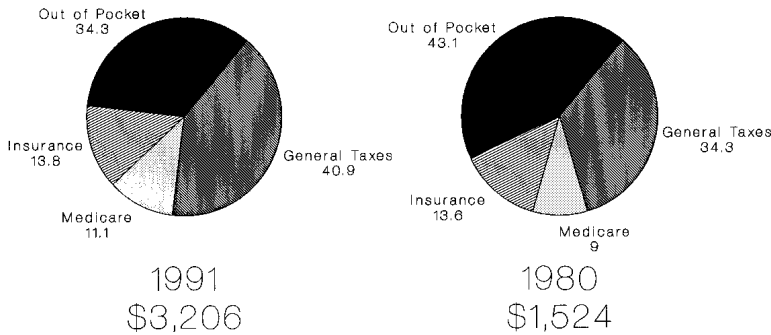


figure 5.

averaged \$2,600 in 1990. To see the impact of health care costs on a product, consider that health care costs add \$700 to the cost of Chrysler's American-built cars, but only \$223 to the cost of its cars built in Canada, where the national health insurance system is financed through income taxes.

Nationally, just over 58 cents go for premiums for employer-sponsored health insurance; nearly 18 cents pay for health care through general taxes; 16 cents go for Medicare payroll taxes; and about eight cents go for other health care costs.

Kentucky businesses spend their health care dollars somewhat differently. Insurance premiums absorb nearly 45 cents of these dollars; general taxes account for just over 27 cents; Medicare payroll taxes cost businesses

about 18 cents; and other health care items cost 10 cents.

Kentucky businesses have changed their spending for health care considerably since 1980. Business insurance premium payments declined from nearly 57 cents of each health care dollar in 1980 to just under 45 cents in 1991. General taxes take 27 cents of that business dollar today, compared to about 17 cents in 1980. Medicare payroll taxes also rose during the decade from nearly 16 cents to 18 cents.

### Our Multi-Payer System

One factor contributing to rising health care costs is the complex system we use to pay for health care. In our current multi-payer system, there are many forms, eligibility requirements, and reimbursement schedules established by the many organizations and govern-

ments that reimburse providers for health care costs. The ratio of hospital, physician, and administrative costs to total health care expenditures tends to rise in a multi-payer system due to the complexity of administration. Today, one in every five of the \$817 billion we spend on health care goes for administrative costs. One very important component of this multi-payer system is that there is no built-in inducement to manage costs because these can often be shifted to other payers, such as government-funded programs.

Many people argue that the U.S. should have a single-payer system, as Canada does. There, health care providers deal only with one payer, one set of forms, one reimbursement schedule, etc. typically established by the government. Administrative costs are typically lower. The General Accounting Office (GAO), an investigative arm of Congress, estimates the U.S. could save roughly \$70 billion or eight percent of all 1991 health care expenditures by switching to a single-payer system. Yet in a single-payer system, everyone has fewer choices. Health care consumers may not be able to visit any physician or request any kind of diagnostic test. Health care providers may not be able to choose any treatment or diagnostic test for patients, nor choose their own type of practice.

Several other factors contribute to rising costs: the lack of primary care physicians, the growing use of expensive medical treatments and technologies, high malpractice insurance rates, and the expanding ranks of elderly and uninsured patients. We will look further at how uninsured and underinsured patients affect the cost of health care.

## Americans with No Health Insurance Coverage

A recent Census Bureau report estimates that one in seven Americans (13%) do not have health insurance. Children make up more than one-quarter of those without health insurance. Almost half of the Americans age

18-21 and one in five of those age 25 to 64 do not have health insurance coverage.

An individual's or family's level of income is a key factor in whether they have health insurance. Nearly four in ten households (39%) with incomes under \$15,000 compared to less than two in ten households (19%) with incomes of \$50,000 or more have no health insurance. Yet it is not clear whether these are individuals or families who are temporarily uninsured or who are constantly without insurance. For example, some people may lose their health insurance if they change jobs, become unemployed, or have a major illness, while others who work only part-time may never have access to health insurance benefits.

Surprisingly, having a job is no guarantee of having access to health insurance. It is estimated that more than half of the 33 million Americans without health insurance are employed or are dependents of employed persons who work full-time year-round.

How does this happen? In most cases, these individuals work for smaller businesses who simply cannot afford the high cost of health insurance for their employees. Health insurance for employees represents the biggest

share of business health care dollars. In fact, businesses pay just over two-thirds of the total cost of private health insurance, while families pay about one-third. And every year, the cost of employee health benefits increases.

A recent national survey (KPMG Peat Marwick Survey of 1,057 Firms, 1992) indicates that between 1991 and 1992, businesses paid 10.9% more for their employees' health benefits, an increase three times more than the rate of inflation. However, more employees also were being asked to pay a portion of the premiums for their employer-sponsored health benefits, while employee deductibles and co-payments also rose (Figure 6). For some workers, these personal costs put their employer-sponsored health insurance beyond their reach. As a result, some employees choose to opt out of employer-sponsored health insurance and shift those monies to more immediate family costs.

## Americans with Inadequate Health Insurance Coverage

A growing number of Americans are realizing that even though they may have health insurance, they are in fact underinsured; that is, their health insurance is not sufficient to protect them from major financial loss in the event of a serious illness or injury. Health insurance policies vary in the degree of coverage they provide for hospitalization and other health care costs. As a result, having health insurance does not guarantee protection against loss. Persons with chronic illnesses or those requiring special services (e.g., physical or occupational therapy) often must assume these costs themselves. But underinsured persons sometimes find that their insurance does not cover even the costs of routine or preventive health care. Moreover, some health insurance policies have lifetime limits; that is, there is a cap on the total amount of covered costs during a specified time period (e.g., a 12-month period). This means that in some situations a seriously ill or

critically injured person may "run out" of health insurance coverage.

The growing number of underinsured Americans means that people often delay seeking health care because they cannot afford the out-of-pocket costs. So, minor problems become major health care crises, and eventually, many of these underinsured Americans must seek public assistance to cover their health care costs.

## What Are the Suggestions for Reform?

The suggestions for reform are tied in with the characteristics that people equate with an ideal health care system. The key ideas most often discussed are universal coverage, portability, comprehensiveness, and accessibility. Some also suggest that a single-payer system is an important aspect of an ideal health care system.

■ **Universal coverage** occurs when all persons, regardless of their income, employment status, family status, or access to private health insurance can receive at least a minimal level of health services. Underlying the argument for universal coverage is a belief that all Americans have a right to a certain level of health care services, that in fact, the principles of "life, liberty and the pursuit of happiness" have meaning only when people do not live in fear that an injury or illness cannot be treated because they cannot afford treatment.

■ **Portability** occurs when employees can carry health insurance with them if they take a new job, retire, or become unemployed for a period of time.

### Who Pays What Share of Private Health Insurance Costs?

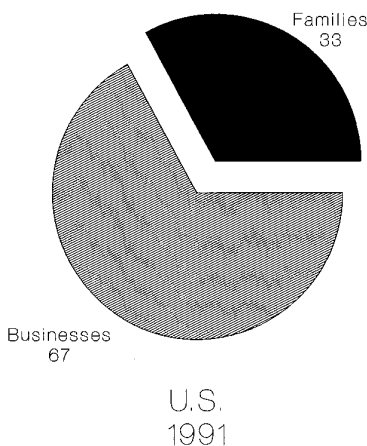


figure 6.

### Kentucky Family Health Care Costs

Average Family	1980	1991
INCOME	\$17,675	\$29,529
HEALTH COSTS	\$1,524	\$3,206
% to Health Care	8.6%	10.9%

figure 7.

Portability also applies to family health insurance that one spouse has that can continue to cover other family members if there is a death or divorce; other family members can still have health insurance coverage through the plan for a period of time. Portability, therefore, recognizes that individuals' employment or marital circumstances may change and result in periods when there is a gap in their health insurance coverage. An ideal system of health care would make provisions for these gaps in coverage.

■ **Comprehensiveness** refers to the kinds of services that would be provided by an ideal health care system. A comprehensive health care system would provide all basic health services (e.g., immunizations, well-baby care, physician visits, and diagnostic testing for simple illnesses and injuries, prenatal care, maternal care) as well as services for acute care (e.g., major surgery, broken bones) and extended care (e.g., physical/rehabilitation therapy).

■ **Accessibility** means that all persons, regardless of place of residence, income, race, or other characteristics would have access to health services. Simply having health insurance is not enough to assure that health care is accessible. There are many areas with no health care providers or service centers, and so in this case the ability to purchase health care is somewhat meaningless. An ideal health care system would ensure that there are no under-served areas.

For health care to be accessible, individuals must also be able to get to these health services; that is, they must have transportation, and persons with limitations on their physical mobility must be able to enter the site where the services are available.

■ A **single-payer system** is the approach to national health care in many other industrialized nations, such as England, Canada, and Australia. Most health care is provided and paid for by one entity, such as the government or a quasi-governmental agency which has negotiated health care prices with all providers. A single-payer system reduces the administrative costs

of paying for health services by eliminating the numerous forms currently required in our multi-payer system.

## Current Proposals for Health Care Reform

The various proposals for health care reform at both the state and national level incorporate most of these ideas. Certain terms keep appearing in all these discussions, and what follows is a brief description of some of the most prevalent ideas.

■ **Pay or Play** requires all employers to provide health insurance for their employees or pay a "tax" into a separate fund that would provide coverage for all uninsured employed persons. Employers would choose either to make their own arrangements for insurance ("pay") or to participate in a government-sponsored program ("play"). However, all employer-sponsored insurance programs would be required to meet minimum benefit standards. This reform proposal contributes to universal coverage by linking employment to health insurance benefits.

■ **Mega-Pool** is a term used to describe a government-sponsored insurance program that pools public employees, individuals in current government insurance programs (e.g., Medicare and Medicaid recipients, Workers' Compensation Health Insurance), and individuals or businesses who choose to participate into one large pool of insurance beneficiaries. The mega-pool enables the state to negotiate with health care providers for a payment structure that yields the highest quality care for the lowest possible cost. The mega-pool provides a means for all persons, regardless of their employment status or income, to have access to at least a minimum level of health insurance.

■ **Mandated Health Benefits** establish minimum benefit levels for all

health insurance programs in the state or nation. Typically, the mandated benefits cover emergency, primary and preventive care, diagnostic testing, physical and speech therapy, and mental health counseling. Mandated benefits ensure that all persons have access to essential health services regardless of who provides their health insurance.

■ **Health Insurance Reforms** focus on universal coverage and insurance costs. There are several insurance reforms that could help achieve universal coverage. Most proposals call for the ending of exclusions for pre-existing conditions. This means that a medical condition that an individual has before he or she submits an application for health insurance may not be excluded from coverage, nor can the individual be denied insurance because of such conditions. Guaranteed renewal of an existing insurance policy is another method of assuring universal coverage, since it will end the practice of dropping insurance coverage for persons who develop medical conditions requiring expensive treatments. Portability is assured by requiring the continuation of insurance coverage for a period of time if the covered individual changes jobs, retires, or becomes unemployed. If the covered individual had a family policy, family members are still covered for a period of time if that person dies or divorces. Most reform proposals also include changes in the way in which insurance rates are set.

■ **Tort Reform** is another issue in the reform of health care. Tort reform attempts to control health care costs by either limiting the amount of money that can be awarded to a person who wins a malpractice case or limiting the kinds of claims that can be made against a health care provider, or both. There has also been discussion of controlling the costs of malpractice insurance by either setting limits on policy costs or by providing subsidies to health care providers who carry malpractice insurance.

Underlying these proposals is the belief that increases in the costs of malpractice insurance and the size of

malpractice awards force health care providers to pass those costs on to consumers. Others argue that these trends force health care providers to practice “defensive” medicine. This means that all possible tests are ordered or procedures performed to protect the health care provider from claims of malpractice.

### ■ Reform of the Health Care

**Delivery System** acknowledges that, too often, the people who need health care are not where the services are located. These proposals focus on improving access to health services for all persons, regardless of where they live. One reform approach is to re-orient health services toward primary and preventive care by:

1. offering incentives for physicians who choose to work in the primary care areas of family or general medicine, obstetrics or gynecology, pediatrics, or internal medicine;
  2. expanding the role of physician extenders, such as nurse practitioners and physician assistants; and
  3. offering incentives for both these types of health care providers to locate in medically underserved areas.
- Together, these reforms will improve accessibility of health services by expanding the number of front-line health care providers and encouraging them to work in communities that lack even minimal levels of health services.

Other proposals target the distribution of health care facilities so as to enhance accessibility to health services. These proposals start with the assumption that while all communities need access to facilities (such as clinics or hospitals) that provide basic or general health care as well as emergency services, most communities cannot support hospitals with major surgical or coronary care units, or very costly medical technologies. As a result, these proposals seek an efficient balance between where consumers and health services are located.

■ **Quality of Care Reforms** seek to enhance the quality of health care received by all Americans through guidelines that establish standards of care and outcome measures. Emphasis is also placed on case management, or the coordination of required health services and the monitoring of service delivery and costs.

Underlying these proposals is the belief that appropriate care does not entail doing everything, especially if this level of care were to entail dangerous or excessively costly practices. Hence, it is possible to manage health care services more efficiently and, in doing so, reduce costs from unnecessary or duplicative practices.

### ■ The Patches (“PACHS”) Approach to Fixing our Health Care System.

Generally when we talk about health reform, we focus almost entirely on cost. The national emphasis on reducing the budget deficit tends to drive all policy changes toward reducing costs first and addressing other issues later. But there are other very important issues in health reform which desperately need attention. An alternative approach is the “PACHS” perspective, which refers to PREVENTION, ACCESS, CONSUMER, HEALTH, and SOCIAL PROBLEMS. This perspective considers some unanswered questions in health reform that include: How can we set up a health care system that pays more attention to health and prevention than to illness? How can we address access issues such as too few primary care physicians, or services which are centralized in urban areas? How can consumers be more involved in health care decisions? How do we address the socioeconomic problems that are a factor in how healthy or sick we are and whether we die young or live to an old age? These issues are very important, but they are not the central focus of the cost-reduction approach to health reform.

## Conclusion

Good health is essential to an individual’s performance in work and in school. Therefore, basic health care services are an essential component of a successful educational system and economy. Today, too many Americans find themselves locked out of the health care system by an absence of services and providers or a lack of money, and all Americans are increasingly dissatisfied with the spiraling costs and erratic quality of health services. We are facing a dual crisis of confidence and access to health care, and the pressures for reform will continue to mount (Figure 7).

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*\* This publication was drafted under the sponsorship of the Extension Task Force on Health and Safety, Committee on Community Health Services, whose members include Doug Choate, Jerri Cockrel, Karen Davis Parker, Darlene Forester, Starr Gantz, Lori Garkovich, Linda Kiesel, Richard Maurer, and Joanne Myers.*

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# Exploring • Health • Issues

## Coming to Terms with **Health Care Reform**

### PART II.

## Health Reform and Insurance Terms

Probably many of us have tried to read the “fine print” in our health insurance policies and wondered, “Why can’t they say this so a person can understand it?” — or wondered, as we have read or listened to news stories about proposals for health care reform, “What are they talking about and what will this mean for me and my family?” Too often, the facts are difficult to understand because of the acronyms, jargon and unfamiliar terms used to present them. What follows are some of the terms we commonly hear when people talk about health reform and health insurance. While some might argue about particular parts of these definitions, we believe the definitions offer a general sense of the meaning of each term.

### ■ Accessibility

This is the degree to which persons are able to obtain health services regardless of their income, race, place of residence, or source of health insurance. For health care to be accessible, there must be health professionals in the area and individuals must be able to get to these health services; that is, they must have transportation, and if they have limitations on their physical mobility, they must be able to enter buildings where health care is provided.

### ■ Assignment of Benefits

When visiting a physician or receiving other health services, a consumer may sign a form “assigning benefits” directly to the health care provider. This means that the consumer’s health insurance, whether public or private, will send payment directly to the health care provider if the provider has agreed to “accept assignment.” However, some providers may refuse to take these “assigned benefits.”

### ■ Benefit Period

A health insurance policy is in effect for a specified period of time or benefit period. During this time, all benefits (i.e., types of health services paid for under the policy) are in effect and the insurer is obligated to pay for these benefits under the terms of the policy.

### ■ Bridging

A private health insurance policy provided by an employer offers a period of extended coverage to “bridge” that time after an employee changes jobs or retires. This enables the employee to obtain new insurance coverage.

### ■ Capitation Payment

A method of payment for health services. The health care provider is paid a fixed (per capita) amount for each person receiving care regardless of the number or nature of services provided. It is the usual form of payment for health maintenance organizations (HMOs) and sometimes for preferred provider organizations (PPOs). It reduces health costs by encouraging more conservative health care delivery.

### ■ Catastrophic Health Insurance

This is a specialized form of health insurance that provides protection against the very high costs of severe or lengthy illnesses or disabilities. Catastrophic illnesses or disabilities may exceed the limits of more common forms of insurance and, therefore, strain the financial resources of most families.

## ■ Certificate of Need

This is a form of regulation at the state level that manages capital expenditures (i.e., construction of new buildings, additions of new beds) by “institutional service providers” (e.g., hospitals, nursing homes) to prevent the duplication of services and facilities. This regulation requires institutional service providers to demonstrate a need for new or expanded services. Since capital expenditures are a part of operating costs that are passed on to consumers, this form of regulation can contribute to controlling rising health care costs. On the other hand, this may explain why your community doesn’t have certain kinds of health services: the state did not determine that a need exists in your community.

## ■ Community Rating and Risk Pools

These are two ways of setting the rates for health insurance premiums. A community rating averages the health risks across all members of a “community” (e.g., all state employees, members of a cooperative) and in doing so averages the costs of providing health services to all members. Risk pools are similar. They are large groups of persons who share some common characteristic (e.g., union membership, employment in the same kind of job) and who receive a lower or higher insurance rate by virtue of this common characteristic.

## ■ Coordination of Benefits

If a consumer has health insurance coverage from more than one source, payment for health care services will be “coordinated” by the insurance providers so that one assumes primary responsibility for payment and the other insurance provider(s) pay the remainder. For example, a couple may both have health insurance through their individual employers, and the

husband’s insurance may be a family policy. If the wife has surgery, her policy will cover the costs up to her policy’s stated limit, and the husband’s family policy will assume payment of residual costs not covered by her policy.

## ■ Co-Payment

The percentage of a medical bill that the person covered by a health insurance plan is required to pay for each visit to a health care provider, a prescription, or other service (e.g., physical therapy or X rays). Co-payments are one way insurance plans try to limit excessive or frivolous use of health services.

## ■ Cost-Benefit Analysis

A method of assessing the monetary costs of a particular health service against its benefits. For example, it costs approximately \$3 to provide a measles immunization but \$2500 to hospitalize a child with complications from measles. If a child who has not been immunized gets and gives measles to many others, the total cost of not immunizing would also include the costs of all the medical care and lost productivity that occurs as a result of a measles epidemic, which could have been eliminated if all children had been immunized. Only those costs and benefits to which a monetary value can be attached are included.

## ■ Cost Containment

A general term that applies to any effort to control the overall cost of health care services without lowering the quality of care. The purpose of cost containment is to reach a reasonable cost for health services provided to consumers.

## ■ Cost Shifting

When persons who are insured or are paying for their own health service receive a bill, the cost of the service or care is often higher than its actual cost. This is to make up for the losses

to the physician or hospital from low government reimbursements (through Medicare or Medicaid) or from providing services to nonpaying patients. With cost shifting, those who have the resources to pay for care absorb the costs of providing services to those who cannot pay.

## ■ Deductible

Under most insurance plans, a consumer must personally pay for some of the costs of a health service before the insurer will begin to cover all or part of the remaining costs. A deductible may be a fixed dollar amount (for example, your insurance may require you to pay for the first \$500 of your health care costs in a given year), or the deductible may be a percentage of the value of a specific service (e.g., you pay the first 20% of your hospitalization costs) over a period of time.

## ■ Employer Mandates

This is a type of reform that builds on the current health care system. Businesses above a certain size would be required by law to provide basic insurance to employees. Smaller businesses and self-employed persons would have to “play or pay”; that is, they would have to provide insurance or pay a special payroll tax into a public insurance fund that would offer insurance to uninsured workers. Medicaid would be expanded to cover the unemployed. To control costs, a national or state agency or board would set yearly spending limits for health care and would set up negotiations between payers and providers to set fees for health care.



## ■ ERISA

### *(Employee Retirement Income Security Act of 1974)*

This act of Congress, also known as the Pension Reform Act of 1974, regulates employee benefit plans. One of its provisions exempts all self-insured health plans from state regulation. If a state passes a legislative requirement for a minimal level of employee health insurance, this exemption would exclude self-insured employee health plans from this regulatory requirement. A growing number of large private companies are now self-insurers and so would be exempt from state mandates.

## ■ Exclusions and Pre-Existing Conditions

These are medical conditions or health services that are excluded, or not paid for, under a health insurance policy. For example, certain kinds of health services, such as physical therapy or mental health counseling, are often excluded from coverage under a health insurance policy. A medical condition a patient had before he or she submitted an application for health insurance is often excluded from coverage as a “pre-existing condition.” This pre-existing condition may be the result of a birth defect (e.g., spina bifida, congenital heart defect), an accident or injury (e.g., paralysis, loss of limb), or illness (e.g., AIDS, stroke, cancer).

## ■ Global Budgeting

This is a plan to put the entire health care system on a yearly budget. Physicians and other health providers would bargain with the state to figure out their share of the budget.

## ■ High Risk

Persons seeking health insurance are rated or classified by the insurance company according to the company’s estimate of their likelihood of injury or illness. Each company sets up classifications of people that they believe to be at higher risk to injury or illness than others. These classifications are based on a person’s occupation (e.g., mining, farming), family history (e.g., diabetes, high blood pressure), or lifestyle (e.g., sky diver, smoker). Persons classified as “high risk” may be denied health insurance or charged a higher premium. An estimated 2.5 million Americans are uninsurable because they are considered “high risk.”

## ■ Lifetime Caps

This is a ceiling that is placed on the lifetime costs to an insurance company for the treatment of a consumer’s particular health problem. After a consumer reaches this cap, all costs become the consumer’s responsibility.

## ■ Malpractice Costs and Malpractice Insurance

Malpractice costs refer to several costs associated with the delivery of health care. These include: 1) the costs of malpractice insurance that health professionals purchase to protect themselves against the costs of being held responsible for a bad outcome of care; (2) the costs of malpractice lawsuits; and (3) the tests or treatments that health professionals order to protect themselves against lawsuits. It is argued that all of these contribute to higher health care costs.

## ■ Managed Care

Managed care encompasses several ways of providing health care more efficiently. In one approach, guidelines are established that define appropriate types and levels of care for specific illnesses. These guidelines are used to reduce costs and prevent the excessive use of health services, including second opinions and needless diagnostic tests. As a way to organize the delivery of health services, the term refers to several related types of health care delivery systems that are almost exclusively sponsored by employer group health plans. Following are four different approaches to managed care.

### **Case Management**

An increasingly popular approach to managed care that focuses on a cluster of administrative services. These services include assessment of the patient’s condition, coordination of the required health services, monitoring service delivery and costs, and evaluation of outcomes. Case management is a way to provide appropriate care in a cost-effective manner and with continuity of care.

### **Health Maintenance Organization (HMO)**

A way to provide comprehensive prepaid health care to a group of “subscribers” or members by a group of health care professionals. HMOs are regulated under special statutes rather than under state insurance regulations. These special statutes establish formal grievance procedures for members as well as quality-assurance programs. When individuals join an HMO, they (or their employers) pay a set fee per month that entitles the members to any and all services necessary. The types of health services covered by the prepaid fee will vary somewhat among HMOs. For example, some will include one year of physical therapy or outpatient mental health services while others may not. Some

HMOs will charge a “co-payment,” or small fee for a physician visit or prescription, but others do not. Members receive most of their services from the physicians within the HMO who typically receive a salary rather than fees for services.

### **Exclusive Provider Organizations (EPOs)**

While similar to HMOs, these health care organizations are regulated under state insurance laws rather than the special statutes for HMOs. As a result, they do not have the same consumer safeguards, such as formal grievance procedures, that are found in HMOs.

### **Preferred Provider Organizations (PPOs)**

These are networks of physicians and hospitals who have agreed to provide a schedule of health services to the members of a sponsoring group at a discounted price. These differ in terms of how they are organized and the extent to which consumer members can seek health services from physicians outside the organization and have the costs paid for by the organization. Providers are paid on a fee-for-service basis.

## **Managed Competition or Market-Oriented Reform**

This approach relies on free-market competition to reduce health care costs. Individuals and families would be required by law to carry at least a minimum catastrophic health insurance policy. Tax breaks that companies and individuals receive on health benefits would be repealed. Most employers would no longer provide insurance, but would instead give this money directly to employees. The government would provide financial assistance to the working poor and some middle class people through tax credits. Individuals and their physicians would

decide what types of health services are appropriate. Insurance underwriting practices would be regulated to ensure that certain individuals or groups currently being denied coverage for pre-existing conditions or because of high risks, or those being forced to pay higher rates for the same coverage, would receive insurance at a fair rate. It is assumed that these steps would create a large, efficient, and competitive private market for health insurance that would drive down health insurance costs.

## **Maximum Out-of-Pocket Limits**

This proposal would set a limit on the maximum cost for health services that an individual or family would have to pay. This limit could be set as a percentage of the annual income of low-income Americans to ensure that health care does not create a financial burden. Some insurance policies already establish this limit for their policy-holders. Under this proposal there may be no lifetime caps.

## **Medicaid**

This is a state-administered program that provides health services to low-income persons. Health services are provided by physicians, hospitals, clinics, and nursing facilities in the community and are reimbursed by the state. The federal government establishes minimum services and eligibility guidelines for the program, but each state determines who is eligible, whether other health services are covered, and how providers will be paid for different types of services. As a result, there are considerable differences among states in terms of eligibility, services, and payments to providers. The federal government provides one-half of the funding for Medicaid. At least two-thirds of Medicaid benefits go to elderly or disabled persons who have already spent all their own financial resources on health care.

## **Medicare**

A national health insurance program created in 1965 for all persons 65 and older who receive Social Security or Railroad Retirement benefits as well as the disabled of any age. It is funded through a payroll tax on current workers and employers, and through premiums that some people pay for an optional plan. Medicare is not “means-tested”; that is, persons receive benefits regardless of their income or personal wealth. The basic plan covers hospital costs. An optional plan (Part B) covers 80% of the cost of most other health services.

## **Mega-Purchasing Pool**

This refers to a proposal that all Medicare, Medicaid, and state employees receive health insurance through a state or federally sponsored program.

## **Multi-Payer System**

This is the current U.S. system of paying for health care costs. Health care is paid for from a variety of public and private sources, and each has its own eligibility requirements, methods of reimbursement, and required forms.

## **National Health Insurance**

In this proposal, the federal government would mandate a single national health insurance plan, funded possibly through income taxes. All persons, regardless of income, employment, or current health status, would have universal access to health care without deductibles or co-payments. Therefore, even if you changed jobs, became unemployed, or moved to another state you would have insurance coverage.

## ■ Pay or Play

This type of health system requires employers to provide health insurance for their employees (“play”) or pay a type of “tax” into a separate fund that would provide coverage for all uninsured employed persons. This permits all employers to choose between making their own arrangements for insurance or participating in a government-sponsored insurance program. Under a “pay or play” system, certain levels of insurance are mandated.

## ■ Portability

This refers to whether you can retain your insurance coverage when you change jobs, retire, become unemployed, etc. Portability is important since it provides a bridge of health coverage for individuals who are in transition.

## ■ Pre-Authorization

Under certain types of health insurance programs (e.g., health maintenance organizations, preferred provider organizations), a consumer must receive approval or authorization from their primary care physician or another specified health provider to see a specialist or visit an emergency room. This is a way to more effectively manage health care costs.

## ■ Premium

This is the monthly cost a person pays for health insurance coverage. Persons obtaining their health insurance through an employer may receive the total or partial cost of their premiums as an employee benefit.

## ■ Pre-Payment

This is a payment made in anticipation of health services that a person may need in the future. In some cases, the pre-payment is made to an organization, such as a health maintenance organization, which arranges for and provides needed

services, while in other cases the pre-payment is made to an insurance company.

## ■ Rate Review

Rate reviews typically are conducted by a governmental agency or insurance organizations to determine whether proposed charges (rates) by health care institutions are appropriate based on several criteria, such as acceptable returns on investments. Proposed rate increases found to be inappropriate or excessive are not allowed as part of the reimbursement under insurance or state (e.g., Medicaid) or federal (e.g., Medicare) programs.

## ■ Rationing

Rationing limits the amount of health care provided to a patient or the types of conditions or patients covered by an insurance program. Rationing may be based on the patient’s ability to pay for health services or the availability of the care. Today, organs for transplants are not readily available, and access is determined by, among other things, the severity of the individual’s illness and the degree of match between the donor and the recipient. Rationing can also be a method of allocating more costly and specialized health services (e.g., kidney transplants, coronary by-pass surgery) among Medicaid recipients to maximize the number of persons who can receive primary care or less specialized services.

## ■ Regionalization or Rationalization of Services

In an effort to assure access to appropriate health services in all geographic areas, this practice builds on the existing referral patterns and the roads that connect consumers to health care services. Regionalization moves toward a more efficient delivery of health care by reducing duplication of health services in some areas and ensuring that underserved areas have needed health services.

## ■ Re-Insurance

Health insurance companies may purchase insurance to protect themselves against very high claims so as to reduce potential losses in the future. This is a relatively complicated approach to help insurance companies lower the risk they take under the assumption that anyone they insure could generate the maximum in medical costs due to a catastrophic illness. Re-insurance protects a health insurance company from the risk of bankruptcy which might occur if the company has to spend very large sums of money for many very sick persons. A state might provide funds for re-insurance.

## ■ Self-Insured Business

A business may take the money that it would have paid to a private insurance company as health insurance premiums for its employees and use this to directly pay for its employees’ health care. In this manner, the business assumes the responsibility for servicing its own employees’ health care needs. Today, a growing number of all employer-provided health insurance coverage is through self-insurance.

## ■ Single-Payer System

This system of financing health care is found in many other industrialized nations, such as England, Canada, and Australia. Under a single-payer system, most health care is provided and paid for by one entity such as the government or a quasi-governmental agency that has negotiated health care prices with the care providers. A single-payer system would not necessarily eliminate insurance companies.

## ■ Small-Group Reform

These are approaches to providing health care designed to make it easier for small businesses to offer health insurance coverage for their employees.

## ■ Third-Party Payer

This is any organization, such as an insurance company or a government agency, that pays for the health care costs of a patient. Americans who have access to health insurance or receive health care under Medicaid or Medicare programs have services paid through a third-party payer.

## ■ Tort Reform

These are reforms aimed at controlling the amount of money that can be awarded to someone who claims he or she was injured as a direct result of treatment (or lack of treatment) related to a health condition. Tort reform may also limit the kinds of claims that may be brought against a health provider. For example, some states have established “no-fault” compensation for certain types of impaired infants. Finally, it may consist of providing state financial subsidies to health providers to help cover the cost of malpractice insurance.

## ■ Uncompensated Care

The sum of non-reimbursed care absorbed by a health professional (e.g., physician) or organization (e.g., hospital) for health services provided to persons who do not have insurance nor the funds to pay on their own. This also includes the difference between the actual cost of the health care and the reimbursements for that care from Medicaid and Medicare.

## ■ Underinsured

Health insurance policies vary in the degree to which hospital and other medical costs are covered. At one end are “comprehensive” plans that cover all hospital and medical costs. At the other end are minimal “catastrophic” or “major medical” plans that cover only hospitalization and critical medical care. These minimal plans typically require co-payments and have a large deductible that the insured person must pay before the insurance begins to pay. Persons are considered to be underinsured if they must pay for the majority of their health care.

## ■ Underwriting

Before a health insurance policy is issued, the application and medical information on the applicant is reviewed. A physician often will conduct a physical examination of the applicant, and the applicant’s medical history may also be considered to determine the risks (i.e., family medical history, personal lifestyle) associated with providing health insurance to the applicant. Individual underwriting or rating is not the same as “Community Rating” where all members of a large group pay the same premium rate.

## ■ Universal Access or Universal Coverage

This is a method of making health care available to all persons regardless of their income or access to private health insurance (e.g., employee health insurance). Under this method, all conditions are eligible for coverage; that is, pre-existing conditions are not excluded from covered health services.

## ■ Usual, Customary, and Reasonable Charges (UCR)

Most health insurers use some type of fee schedule base to determine how much to pay providers. UCR refers to fees for medical care which are determined by the insurer to be usual, customary, and reasonable. UCR charges for the same service vary across the U.S., between rural and urban areas, and may vary by insurer within a region. An insurer may reimburse a provider at 100% of the UCR charge, or the insurer may reimburse at, for example, only 80%. In the latter case, the consumer would be expected to cover the difference. Today, only about half of the privately insured persons under the age of 65 with surgery benefits are fully insured for the usual, customary, and reasonable surgeon’s fee.

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# Exploring Health Issues

## Coming to Terms with Health Care Reform

### PART III.

## Health Care Terms

The health care industry is the fastest growing one in America. Every day it seems we hear about a new kind of health care service, technology, or provider. Trying to make sense of our health care options is difficult when we are not even sure of who is providing our health care or where we ought to go to find a particular health service. This is a guide to the persons and institutions that deliver health care and the kinds of health services that are available.

### ■ Ambulatory Care

This is health care provided in a physician's office or health center in which the patient is treated and leaves the same day. This is also called outpatient care.

### ■ Ancillary Services

These are the diagnostic and therapeutic services that are provided by hospitals, clinics, and other health care providers. Diagnostic ancillary services would include X rays, MRI (magnetic resonance imaging), laboratory tests, or other types of services that assist a physician or other health professional in making a diagnosis. Therapeutic services would include physical, speech, or occupational therapy, psychological counseling, or other types of services that assist a patient in recovering from an illness, disease, accident, or emotional problem.

### ■ CAT Scanning (Computerized Axial Tomography)

A type of X-ray technology that provides detailed images of bones, organs, and other body tissues by using a computer to build an image on a computer screen.

### ■ Chronic Conditions

These are illnesses (e.g., rheumatoid arthritis, high blood pressure) that last a long time, usually more than a year, and therefore usually require long-term health care.

### ■ Consent or Informed Consent

Before any major medical procedure, such as surgery, a health provider obtains consent from the patient by explaining what will happen and offering other information about the procedure. If the patient is unconscious or underage, consent is obtained from the nearest relative. After this, a form is signed indicating that this information has been provided and that it is understood. This represents the patient's consent to the medical procedure. Consent is a way to assist consumers to be more knowledgeable about their health care and the potential negative effects of some procedures.

### ■ Diagnosis Related Group (DRG)

In an effort to reduce the increasing costs of Medicare, the federal government instituted a way to classify patients by health problems that are related. There are nearly 500 diagnostic groups established by the federal government. Rather than reimbursing a hospital for each individual service it provides to the patient, the federal government reimburses a set amount based on the patient's diagnosis. When DRGs were first introduced, many people in

health care thought that private insurance companies would adopt this federal approach for reimbursement. However, this has not happened.

## ■ **Emergency Medical Service (EMS) System**

An emergency health care system that uses ambulances and trained technicians to bring rapid health care to people with injuries or serious illnesses.

## ■ **Fee-for-Service**

This is the usual method by which physicians and other health care providers in the U.S. bill their patients. A patient or consumer is charged for each service or action that the provider performs. With this system, the costs of health care increase if more types of service are provided or more expensive procedures (e.g., CAT scans) are substituted for less expensive procedures (e.g., X rays). The alternative to fee-for-service reimbursement is making the provider a salaried professional.

## ■ **Home Health Care**

This type of health care is provided to individuals in their own home by a health professional or other provider. It may range from skilled care, such as administering prescription drugs or changing surgical dressings, to assisted care, such as cooking special meals or helping the individual to become mobile. This health care worker is sometimes called a home health aide or a homemaker.

## ■ **Hospice Care**

Hospice care is a coordinated program of home and inpatient services for terminally ill persons. It may be provided by a social worker, nurse, physician, psychologist, chaplain, homemaker, or trained volunteer. Its purpose is to help the terminally ill individual and his or her family cope with physical, emotional, and spiritual problems. Many hospice pro-

grams also provide counseling for family members following the death of the terminally ill patient.

## ■ **Levels of Care—**

### **Primary Care**

This is the basic, or the least specialized, kind of health care, such as preventive services (e.g., immunizations, routine physical exams) or the diagnosis and treatment of common illnesses (e.g., flu, minor infections) or injuries (e.g., broken arm, first or second degree burns). This may be an individual's only contact with the health care system, or it may be the entry point to more specialized care. Primary care can be provided in a doctor's office or as an outpatient in a hospital.

### **Secondary Care**

This level of care may be found in full-service regional hospitals. It refers to medical and surgical diagnostic and treatment services for complicated medical problems which could potentially become life-threatening if not promptly treated. It typically requires staying in a hospital for a period of time.

### **Tertiary Care**

This level of care is found in full-service and typically urban-based hospitals. It refers to the availability of specialized medical, diagnostic, and therapeutic services for unusual and complicated cases, including specialized surgical care and other specialized care that may be provided on an outpatient basis.

## ■ **Long-Term Care**

Persons who are chronically ill, elderly, and/or physically disabled may require health care on a long-term basis either in their home or in an institution. The costs of long-term care may be covered by Medicaid, but generally there are upper limits after which all costs must be paid for by the patient.

## ■ **MRI**

### **(Magnetic Resonance Imaging)**

A method of viewing the structures of the body through the use of a magnetic field rather than X rays. Although it is much safer than traditional X-ray techniques, it is much more costly and requires increased usage to be cost effective. Typically several health care providers will share the cost of purchasing and using an MRI machine.

## ■ **Types of Practice—**

### **Group Practice**

An association of several physicians or other types of health care providers. In a group practice, all income from services provided is pooled and then divided among the members of the practice according to some pre-arranged plan.

### **Health Maintenance Organization (HMO)**

A type of system for providing comprehensive prepaid health care to a group of "subscribers" or members by a group of health care professionals who provide nearly all services. When individuals join an HMO, they (or their employers) pay a set fee per month that entitles the members to any and all services necessary. The types of health services covered by the prepaid fee will vary somewhat among HMOs. For example, some will include one year of physical therapy or out-patient mental health services while others may not. Some HMOs will charge a "co-payment," a small fee for a physician visit or prescription, but others do not. Members are generally assigned to a personal physician, who is typically on a salary with the HMO, and who manages their access to other services.

### **Independent Practice**

## **Association**

This refers to an association of physicians who agree to provide services at negotiated rates in exchange for increased patient volume. Physicians may be paid on a fee-for-service basis, a set amount per patient, or through risk-sharing arrangements.

## **Preferred Provider Organizations (PPOs)**

Networks of physicians and hospitals who have agreed to provide a schedule of health services to the members of a sponsoring group at a discounted price. Health care providers in PPOs may be required to obtain the plan's approval before hospitalizing a patient, but members are free to visit any doctor in the network. When a member visits a physician or hospital within the PPO network, the employer will pay between 80 and 90% of the costs, but if a member sees a physician outside the network, coverage may be limited to 70% or less of the bills.

## **■ Providers—**

These are individuals or organizations who provide health care or earn their living from providing health care. These include physicians, nurses, or other health care professionals, as well as hospitals, clinics, nursing homes, insurance companies, or other kinds of health insurers. Nearly all of the professionals must be licensed or certified by the state, meeting strict educational and training requirements and often passing a required exam. State regulations determine which professionals can provide what types of treatments. For example, a nurse can give a shot, but only a physician can order one. The professional level of your health care provider influences the costs of your health care. Following are several types of providers in our health care system.

## **Allied Health Care Workers**

This refers to the very large group of health providers who are not physicians, dentists, nurses, psychologists, or pharmacists. Allied health professionals include everyone from laboratory workers, to home health care providers, to X-ray technicians, to physical therapists. New types of allied health care workers are developed each year.

## **Allopathic (MD) Physicians**

Allopathic schools are the most common type of medical school. In Kentucky, both the University of Kentucky and the University of Louisville Schools of Medicine are allopathic medical schools. The educational program is four years, followed by a residency training program which the physician can receive almost anywhere in the U.S. These doctors use surgery or medicines to treat diseases and other health conditions.

## **Emergency Medical Technicians (EMTs)**

These are trained volunteers or paid professionals who provide emergency care and ambulance service. EMTs' authority and ability to perform particular kinds of health care procedures increase with their level of training.

## **Medical Social Worker**

A health professional who assists people in obtaining needed health services and helps individuals deal with the social, emotional, and other problems related to their illness or disability.

## **Mid-Level Providers**

Individuals who have received special training in health care beyond that of a nurse but less than that of a physician. The two most common types of mid-level providers are physician assistants and nurse practitioners. These individuals can assess and manage patients' illnesses but cannot provide the full range of treatments legally available to physicians.

## **Nurse Practitioner**

There are different types of nurse practitioners. All are registered nurses who receive another nine to 24 months of additional training and work under their own professional license as they do in Kentucky. State regulations require nurse practitioners to work with physicians who provide professional consultation and management of patient care. Nurse practitioners do health exams, treat minor and chronic illnesses, and provide patient education and counseling. In most states, nurse practitioners can prescribe certain types of medications, but this practice is limited in Kentucky.

## **Paramedic**

A highly trained member of an ambulance crew who can stabilize patients with life-threatening conditions by performing highly technical procedures without direct supervision from a physician by following standard procedures for particular life-threatening conditions.

## **Public Health Agencies**

Health care agencies that receive public funds from local, state, or federal governments to provide health services in a local area. County health departments in Kentucky are public health agencies.

## **Osteopathic Physicians (DO)/Osteopaths**

Osteopathic medical schools are less common, although there are many osteopathic schools in the Midwest. The educational program is four years followed by a residency training program. Most osteopathic physicians choose to become primary care physicians, and many decide to work in rural areas. There is very little difference between the coursework in an osteopathic compared to an allopathic medical school. However, osteopathic medical school programs emphasize the treatment of the whole body and use nutritional therapies to return the body to a healthy state. Osteopathic students receive special

training in “structural diagnosis,” a method of diagnosis where the hands are used to examine normal or abnormal tissue states. The osteopath is trained to manipulate the bones and joints to hasten healing. Graduates of osteopathic schools enter either allopathic or osteopathic residency training programs, and most graduates spend one year of osteopathic internship training immediately after graduation. Osteopathic physicians are licensed to practice in Kentucky.

### **Physician Assistants (PAs)**

Physician assistants, or PAs as they are often called, usually receive a bachelor’s degree including two years of special training in human biology, diagnosis, and treatment. PAs generally work under a supervising physician who is responsible for the medical care they provide. PAs provide direct medical care, not just patient education. Depending on state licensing, PAs may provide different types of health care, such as giving shots or treating minor illnesses, commonly performed by physicians. This occupation emerged in the 1960s to offset the shortage of physicians. Physician assistants are licensed to practice in Kentucky.

### **Primary Care Physicians**

Primary care physicians are those who receive training to become one of the following types of physicians: family practitioner, general practitioner, internist, obstetrician/gynecologist, or pediatrician. These physicians provide comprehensive health care that helps maintain the basic level of health in a population.

### **Residents/Residency Training**

Today all medical students enter a residency training program after they complete four years of medical school and graduate with an M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) degree. The length of training in these programs varies from three to seven years, after which that person will be a specialist in a specific field of medicine.

### **Specialists/Specialty Training**

Nearly all medical students choose a specialty in medicine. Physicians who choose to become obstetrician/gynecologists, pediatricians, general internists, or family practitioners are usually referred to as primary care physicians. However, today only a small number of physicians enter primary care residency programs. Most get training in other specialties where income is higher, prestige is greater, and the work is different. In the last 20 years, the most often selected specialties were radiology (X-ray and related care), plastic surgery, gastroenterology, neurology, pulmonary (lung), cardiovascular, and anesthesiology specialties.

### **Trauma Hospital**

A hospital that provides expert emergency services to persons with severe, life-threatening injuries. In addition to a staff with special training in emergency medicine, there is a surgery staff and equipment for performing operations with little or no advance notice.

### **Rehabilitative Care**

Individuals who are disabled due to an illness or injury receive rehabilitative care to help them return to customary activity through education and therapy.

### **Respite Care**

Respite care refers to services provided to an individual with primary responsibility to care for an ill, injured, or disabled person and who needs a rest from providing that care. For example, in some communities, respite care is provided to relatives who are caring for an elderly family member where the elderly person may be taken out of the house to a senior center so the caregiver can attend to other household tasks, rest, or simply get some time off. Respite care might also mean that someone comes to the home to watch over the ill or disabled person.

## **Second Opinions**

In some medical situations, a “second opinion” is sought from another health care provider, typically a specialist, to confirm a diagnosis or recommended treatment. A second opinion may be required under some health insurance plans. In other cases, if patients want a second opinion, they must pay for it themselves.

## **Utilization Review**

An evaluation, usually by a third-party payer, of the necessity and appropriateness of health services provided to a consumer. This includes a consideration of whether the procedures (e.g., types of tests ordered) and facilities (e.g., in-patient or outpatient care) were appropriate for the diagnosed condition. Certain regulations may determine how long a provider may keep a patient hospitalized for a specific condition.

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