

## ABC's of Reform: The Alphabet of Health Care

**Introduction:** CodeBlueNow!'s public engagement, consensus building work for the last five years with individuals, groups and other nonpartisan nonprofits clearly points to the public's preference for a 'shared responsibility' model for health care reform. We proposed our *Voters' Health Care Platform* in 2008 based on that work. Several similar 'shared responsibility' approaches have also been proposed by some members of Congress and the President who hope to have one comprehensive bill by June 2009.

A 'shared responsibility' model continues:

- employer participation, but may modify how employers are involved and how they pay for health insurance;
- a private insurance market, but may reshape the existing market;
- public funding for safety net (some proposals expand these programs; others would eliminate Medicare and Medicaid, but create new funding models to protect coverage);
- choice of health plans and providers;
- participation of individuals, employers and government to pay for health care.

This approach would change some existing practices by:

- creating financial incentives with greater rewards for prevention and wellness;
- having better comparative outcome data based on more clinical outcomes research;
- assuring access to health care services, by expanding coverage and insurance options;
- creating incentives for personal responsibility for one's health.

*This Alphabet describes many concepts and sorts through complexities to provide a high level overview of the key issues for the lay reader who may be new to the politics of health care reform. Many of the terms are defined as they would apply to a 'shared responsibility' model while other entries are included because they are frequently used terms in the reform discussion. We think some version of a 'shared responsibility' model with employer, individual and government will be the model proposed this summer.*

## ABC's of Reform: The Alphabet of Health Care

### A

**Accessibility:** All Americans need to be covered. Unless everyone is covered the costs of care for the uninsured will continue to be passed along to those who have coverage, thus continually increasing costs. For example, California estimated that \$400 per person per year of insurance premium costs were caused by the cost of health care services for the uninsured. Access to services is also essential to assure timely attention to illness and to promote health and wellness. Because 60% of all the people who have private health insurance have it through their employers, this is seen as the least disruptive model. Individuals can keep the coverage they have and the current system would not be dismantled, but would be significantly improved.

**Accountability:** Little accountability currently exists from insurers, to employers and employees. For example, small businesses do not have enough clout or bargaining power to demand performance standards from insurance companies. Inserting accountability would improve outcomes and moderate costs. Currently, the Federal Employee Health Benefit Plan model adds accountability by tying insurers' profits to performance criteria. These criteria could be applied to all insurers (See Profit Analysis Factors) in a revised system.

**Affordability:** Administrative simplicity, performance standards and electronic medical records will reduce the spiraling costs by reducing waste, redundancies, and errors, by providing the most effective care, and making health plans more affordable for employers, individuals and other payers.

### B

**Basic Benefit Package:** A standard benefit package for everyone will offer Americans the freedom to take any job they want. Benefits will no longer depend on the job and people will have more economic opportunities and choices. Those employers and individuals who want more benefits can purchase them. Many models exist for a basic benefit package: Federal Employee Health Benefit Plan; Medicare; Medicaid; state specific plans, such as Washington State's Basic Health Plan; TennCare, among others.

**Baucus, Max:** Senator Baucus, D, Montana, Chairs the Senate Finance Committee which is the lead committee on health care reform, along with the Senate's Health, Education, Pension and Labor Committee, Chaired by Senator Kennedy. Baucus has issued a White Paper on Reform which outlines some key provisions of a 'shared responsibility' model.

### C

**Choice:** Individuals and employers will have their choice of health plans; individuals will have their choice of provider.

**Clinical outcomes:** Ongoing and expanded research will add to the existing body of knowledge on health care practices and will lead to the improved patient care. RAND Corporation studies indicate that currently 50% of the care patients receive is either inappropriate, unnecessary or wrong.

**Complementary and Alternative Medicine (CAM):** Widely used at present by many patients, major medical clinics, and hospitals, the majority of Americans think these providers should be included in a basic benefit package. CAM providers include naturopathic physicians, chiropractors, acupuncturists and massage therapists.

**Consistency:** With broad access to a standard benefit package, greater consistency will exist across state lines and will reduce administrative costs and errors. Currently, health insurance policies, benefits, services and regulations vary state by state, making it impossible for employers to offer comparable policies across state lines, unless the company self insures.

**Co-pays:** Will be retained to help control costs by requiring all the participants to pay a share of their health care costs.

## D

**Dartmouth Atlas of Health Care.** This Atlas outlines the care and cost differences for the very same health care condition and treatments across the country.

<http://www.dartmouthatlas.com/> The site includes tools to compare costs and treatment options in various communities. Reducing the variation of care would have a major impact on reducing costs. Treatment costs for the same condition can vary 30% to 50% even in neighboring counties.

**Decision trees:** Software applications that help patients and doctors make better care decisions by raising questions that need to be asked depending on the patient's age, stage of illness, and family health history. Greater use of decision trees could help patients be more engaged in their care and help provider and patient find the best route to care and treatment options.

**Deductibles:** Deductibles will continue to be used and will be one of the decision factors for employers and individuals to use when choosing a health care plan.

**Delivery System:** The organization of medical and health care services and providers, including financial incentives for providers, will be restructured to reward prevention and decrease the incentive for over-treatment in the current fee for service payment approach. The current fee for service, pay for procedure model does not reward doctors for preventive care or early diagnosis. The capitation approach in managed care, however, was seen by some as rewarding under-treatment.

**Diversity:** Research on clinical outcomes will also examine outcomes by ethnic origins, because disease patterns often differ in different ethnic groups, such as earlier and more aggressive breast cancer in women of color.

## E

**Ease of Administration:** A standard benefit package and electronic medical records will make health care options easier for employers and individuals to understand, select and manage.

**Efficacy:** Research on clinical outcomes will increase the body of knowledge on the best and most appropriate treatments given the patient's age, gender, illness and health history.

**Efficiency:** A basic benefit for everyone and an electronic medical record will increase efficiency, thus freeing up money for patient care. Current estimates are that only 50 cents of every health care dollar actually goes to patient care.

**Electronic Medical Records:** Standard electronic medical records will improve the quality of care, reduce errors and improve medical decisions when coupled with clinical outcomes research.

**Employers:** Will continue to play a major role in offering health care benefits. How they pay for health insurance premiums may change in some proposals. Employers are subject to different rules and regulations. Large employers (100+) can 'self-insure their health care benefits and are not subject to state mandates or premium taxes. Smaller employers buy state regulated health plans and are subject to state mandates and insurance premiums.

**Entitlement programs:** These programs cover the costs for those who cannot provide for themselves, such as Medicaid for low income women and children; the blind and disabled; some families below the federal poverty level and for some long term care. Medicare is for people over 65 and the severely disabled. If these programs are not continued in their current structure and financing, the entitlement services and coverage will be continued in another form.

**Equity:** Greater equity will exist because everyone will be playing by the same rules. Currently, individuals and employers have different benefits and different regulations, not only for private insurance, but also in public programs such as Medicaid, which has different services and eligibility in every state (See Taxes).

**ERISA (Employee Retirement Income Security Act):** This legislation from 1974 gave employers the ability to self-insure health care benefits, in addition to setting standards for retiree income and other welfare benefit plans. Will be continued so large employers retain the flexibility they need to operate across state lines and to attract and retain employees.

## F

**Financing:** Four major approaches have been proposed to pay for health care:

*Single payer:* Tax based, government managed health care. It eliminates employers and insurance companies as participants.

*Health Savings Accounts/Vouchers:* Insurance payments migrate from the employer to the individual who purchases benefits from insurance companies. Some keep private insurance companies, but eliminate employers over time. Others eliminate insurers. Health savings accounts and voucher proposals differ. Health Savings Accounts work like a 401(k) plan. The employee keeps the funds in the account and the contributions accumulate over time. Those savings may be inherited by family members when the beneficiary dies.

*Vouchers,* as currently proposed, are used to purchase benefits, but do not work like a 401(k) plan in that the money is not carried forward by the individual. These models also eliminate the employer and change the health insurance marketplace.

*Shared Responsibility:* Continues to use employers, individuals and the government (federal, state and local) to finance the health care system.

**Flexibility:** Having a basic benefit plan enables employers to have greater flexibility in managing their health care benefits, choosing plans that fit their needs and adding benefits tailored to their employees.

## G

**Guaranteed issue:** This provision requires insurance companies to accept all who apply for coverage, regardless of their health status or pre-existing conditions. A major related issue is cost, especially for people with chronic conditions.

## H

**Health Plans:** These are either for-profit or not-for-profit insurance companies that offer specific health care benefit packages, called health plans. This term is also interchangeable with insurance companies. Private insurance companies would be continued in a shared responsibility model, although the insurance market may change.

**Health Savings Accounts:** These accounts work like 401(k) plans. Funds are deposited into an account which can only be used for health and long term care. They are high deductible plans owned by the individual/family. (See Financing). Because this approach is advocated by marketplace proponents, this approach immediately galvanizes the single payer community in vocal opposition.

## I

**Innovation:** By simplifying the current system, more opportunities will exist to identify new and innovative procedures, techniques, services and products. Greater knowledge from clinical outcomes research could lead to new medical breakthroughs because of greater information on effectiveness.

**Insurance:** Health care coverage will continue to use existing or new insurance models, both for profit and not for profit. These plans, however, will be more regulated and subject to greater accountability in performance and transparency in financial reporting (See profit analysis factors).

## J

**Jurisdiction:** Having a standard benefit package will make it easier to know who is responsible for paying claims, overseeing the insurance market, and understanding appeal procedures. This will result in lowering costs associated with the complexity of the current system. Health care benefits and services are currently financed and managed at many different levels, even by cities and counties, so it is often difficult to know who is responsible for paying for and managing health care services, or to whom to appeal if there are errors. (See Taxes).

## K

**Kennedy:** Senator Edward Kennedy, (D, MA) Chair, Senate Committee on Health Education, Labor and Pensions, is the designated lead to introduce bipartisan legislation. Whatever legislation emerges will be the result of close collaboration and cooperation with his Senate colleagues (see shared responsibility).

## L

**Liability:** Some proposals address medical malpractice liability reform to reign in health care costs while assuring patient protection. Medical malpractice costs are indicated as a reason for costs because doctors practice 'defensive medicine' to protect themselves. Some means of reforming the liability system might have an impact on cost reduction.

**Lower Costs:** Lowering administrative costs; assuring the best treatment options based on expanded clinical outcomes research; and eliminating complex, redundant and overlapping regulations and jurisdictions will either decrease costs or lower the rate of cost increases. Currently, health care benefits, rules, regulations and financing vary state by state and depend on whether a company purchases state regulated insurance products or whether the employer self-insures health care benefits.

## M

**Malpractice:** See liability.

**Managed Care:** The term emerged in the late '80s about a new payment system. Doctors and clinics were paid a flat fee per patient per month and were to 'manage' patient care within that 'budget.' (also known as capitation—a flat fee per person). Strong opposition emerged from patients and some stakeholders characterizing managed care as an excuse for HMOs (Health Maintenance Organizations) and insurance companies to deny care to patients. The term managed care is often used as scare tactics claiming it keeps people from getting needed care.

**Medicaid:** Medicaid is a jointly funded federal-state insurance program for low income and disabled people. Medicaid is the fastest growing part of every state's budget. As Medicaid costs grow, funds erode to pay for education, transportation and other important state needs. While Medicaid is jointly funded, the states are free to expand eligibility criteria and benefits.

**Medical Home:** A term used to describe one consistent point of entry to the health care system for every patient. Medical Homes are designed to assure patients have easy access to one provider who takes the lead in coordinating the patient's care and assuring continuity of care. Proponents see this as assuring every patient has a patient advocate who knows their particular care needs. Detractors view this as interfering with a patient's right to see any medical specialist they may need. This is one proposed delivery system change to help improve access and lower costs.

**Medicare:** This is a federally-funded program covering most people 65 and over, disabled persons and those with end stage renal disease. Medicare is financed by a payroll tax and its long-term financial viability is questionable. One proposal explores expanding Medicare to those 55 and over who currently are without insurance and find health insurance unaffordable because of their age.

**Medicare Advantage:** This is a private managed care alternative to Medicare's fee for service program. The current subsidy paid by the federal government to insurers to attract their participation in this program is being examined and may be repealed.

## N

**Not-for-profit/for-profit organizations:** Health insurance plans and hospitals, among others, operate as both not-for-profit and for-profit enterprises. Those entities will continue to operate with these same classifications going forward.

## O

**Opportunity:** Employers and individuals will have greater opportunity to choose benefits, health plans and providers. Individuals will have more opportunities to take the job they want without worrying about losing benefits.

**Options:** Employers and individuals will have more than one health care benefit plan to choose from and may use the provider of their choice.

## P

**Payers:** This is another name organizations that pay for health care are called. They include insurers, employers, states, cities, counties and unions, among others.

**Pooling:** A large part of health care costs are based on group insurance pools. Insurers use these pools to determine health risks of the people in the pool which dictates health care premium costs. One proposal suggests pooling the uninsured age 55 and older into the Medicare program to make their health care premiums more

affordable. Another proposal would have a public insurance plan that would compete with private insurance companies. Another proposal eliminates pools completely. (see underwriting).

**Primary Care:** Primary care focuses on prevention, wellness care and the diagnosis and treatment of disease. Primary care providers include: family practice physicians; general internal medicine physicians; pediatricians; ARNPs (Advanced Registered Nurse Practitioners) and in some states, naturopathic physicians. Under managed care, these providers were called “gatekeepers” since patients were required to see them to obtain a referral to specialists.

**Profit Analysis Factors:** The Federal Employee Health Benefit Plan uses the following weighted guidelines to negotiate with insurers: 1) contractor performance; 2) contract cost risk; 3) federal socioeconomic programs; 4) capital investments; 5) cost controls; and 6) independent developments. These provisions insert accountability into an insurer’s performance and tie their profit to outcomes.

**Public Programs:** Numerous public programs exist, including Medicare, Medicaid, Public Health Service, and the Indian Health Service. These programs are managed by several different agencies (see Taxes). Whether these programs are kept as they currently exist or are modified, these are the “safety net” and entitlement programs that government covers with tax dollars.

**Public Insurance Plan:** The proposal to create a government-run public health insurance plan is very controversial. Proponents say it is a cost effective alternative to existing health plans, lowering costs by 30% to 40%. Opponents believe it is step one to a single payer system. They fear government rate setting would drive people to this plan putting private insurance plans out of business or severely reducing the number of people with private insurance.

## Q

**Quality:** Clinical outcomes research and electronic medical records will greatly increase the quality and accuracy of health care services. Currently, over 100,000 people die every year from preventable medical errors in hospitals alone. Greater clinical knowledge and improved efficiency and accuracy will greatly enhance the quality and safety of patient care.

## R

**Randcompare:** RAND Corporation has a new policy tool to help policy officials, the media and other interested parties compare various characteristics of the numerous health reform policy proposals. While somewhat complex, it offers invaluable insights on different policy options now being considered ([www.randcompare.org](http://www.randcompare.org)). RAND is a nonpartisan, nonprofit organization.

**RVRBS (Relative Value Resource Based System):** Medicare uses this rate structure to pay doctors. The rate structure is being reexamined because the reimbursement favors specialists over primary care (see Delivery System).

**Rates:** Medicare and Medicaid fees paid to doctors vary significantly state by state, even for the same service or procedure. Rate inequities leads some doctors to close their practices to new Medicare and Medicaid patients.

**Regulations:** Health care services and coverage rules and regulation are overwhelming to many providers because of the numerous different agencies involved. Administrative and regulatory simplification would reduce the costs of regulatory burdens.

## S

**Single Payer proposal:** Single payer proposals remove the employer and private insurance companies from the health care system. Funds to pay for the system come from taxes, and in some proposals, from taxes and employer contributions. One agency would manage the health care system, but doctors would keep private practices. Most single payer proposals, to date, do not include cost containment provisions or changes in the delivery system and its current financial incentives. The single payer concept immediately brings intense opposition from the business community as well as many in the health care community.

### **Shared Responsibility Proposals (Baucus, Kennedy, Obama, Wyden-Bennet):**

These approaches retain employers and private insurance companies; expand some public programs; introduce some public/private ventures and offer counseling for small employers and individuals to find the best insurance for the best price (health insurance exchange). Some proposals retain tax exemptions for self-insured employers and union trusts; revise physician compensation with more incentives for primary care and wellness; will most likely propose a management structure much like the Federal Employee Health Benefit Plan with competing health plans in the 10 federal regions or at the state level; cover all Americans, whether through employers or as individuals, or both.

Major reexamination of entitlement programs, such as Medicare and Medicaid, promise to identify more sustainable funding. Financed by reducing waste, greater administrative simplification with electronic medical records, new or different tax structure. Employers, employees and individuals would continue to pay for health plans that continue to use copayments and deductibles. The current Congressional goal is to introduce legislation by June 2009.

The health care reform debate has been dominated by the two opposing extremes: single payer health care vs. health savings account/marketplace health care. There has been no clear voice, to date, for this shared responsibility model. Polls and other research indicate that a shared responsibility model is the most appealing to the majority of the American public. This model, however, will be attacked by supporters of both single payer and the market approaches.

## T

**Taxes:** Taxes are currently used to finance a variety of health care programs:

*Medicare* is financed in large part by a payroll tax on employers and employees. Those currently working finance the health care of seniors enrolled in Medicare. *Medicaid* is paid by state and federal taxes.

*Public Health Service and the Veterans Administration are paid by federal tax dollars.*

*State, county and city public health departments are paid by a combination of federal, state, county and city taxes.*

*Some hospitals form their own “tax districts” so they can collect funds from local residents to pay for part of the hospital’s operating budget.*

*Indian Health Service is funded by federal tax dollars.*

*Community and Migrant Health Centers are funded by a combination of federal tax dollars and other local funding, including foundations and donations.*

*Numerous other public health agencies exist that do not provide direct health care services, such as the other agencies in the Department of Health and Human Services, including Centers for Disease Control and Prevention, the FDA and National Institutes of Health and the Agency for Healthcare Research and Quality, among others.*

## **U**

**Underwriting:** The cost of a health insurance premium is determined by “medical underwriting” or the analysis of the age, gender and health status, and hence ‘health risk’ of the people in a particular insurance pool. Major fights exist over risk pools, community rating and other aspects of underwriting.

## **V**

**Voucher Proposal (Emanuel-Fuchs)** The Voucher proposal would eliminate the employer, keep private insurance, and eliminate insurance pools. Basically, the government gives the individual a voucher for the cost of health care premiums. The individual uses that voucher to ‘buy’ the health plan of their choice. These plans would be tightly regulated and could not deny people coverage based on age, gender, and preexisting conditions. The system would be funded by a new VAT (Value Added Tax) on business products and services. Medicare and Medicaid would be restructured or eliminated.

## **W**

**Wyden-Bennet Plan:** Their bipartisan proposal would give employers and employees the choice of keeping their current health insurance plans or let employers give to employees the amount the employer would have paid for their health insurance premium. The employee would then purchase insurance at the state level from a range of private insurance options. The money given to the employee to purchase insurance is not taxable. Medicare and Medicaid would be restructured. Wellness and prevention incentives are included in the bill.

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*CodeBlueNow! is a national, nonpartisan, 501(c)3 nonprofit based in Seattle, Washington and is dedicated to seeing the public has a voice in health care reform. (www.codebluenow.org)*

