6th Edition

COVERING HEALTH ISSUES

A SOURCEBOOK FOR JOURNALISTS

ALLIANCE FOR HEALTH REFORM

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The entire Alliance for Health Reform staff and our capable interns contributed enormously to update the sixth edition of this book and get it into your hands. You can see them listed on page vi. Deanna Okrent took the lead in updating the chapters on health reform, public health, Medicare, Medicaid and long-term care. Bill Erwin was the lead updater for employer-sponsored coverage, health care costs, mental health, children's coverage, individual coverage and disparities. Kevin Arts was responsible for updating the quality chapter. Anastasia Tirio kept us all on schedule. A special thanks to intern, Zaib Khan, for assisting in various aspects of research and fact checking. We thank Deborah Potter, president and executive director of NewsLab, for the appendix on covering health issues for television and radio.

The sourcebook was designed again this year by Alisa Prendergast of Cyberonyx International and was printed by Doyle Printing of Landover, MD.

Ed Howard
Executive Vice President

THE ALLIANCE FOR HEALTH REFORM'S MISSION

America's health care system is always a work in progress. Every year brings new challenges and new proposed solutions.

In the heat of debate, opinion leaders need an unbiased source of information so they can understand the roots of the nation's health care problems and the trade-offs posed by competing proposals for change. The Alliance for Health Reform (www.allhealth.org) exists to provide that information. We offer a full array of resources and viewpoints, in a number of formats, to elected officials and their staffs, journalists, policy analysts and advocates.

A nonpartisan, nonprofit group, the Alliance does not lobby or take positions on legislation. Senator Jay Rockefeller of West Virginia is our founder and honorary chairman. The diverse board includes distinguished leaders from the fields of health care, business, labor and consumer advocacy. Ed Howard, an attorney long active in national health care issues, heads the Alliance's staff.

Since 1991, the Alliance has organized more than 200 forums in Washington and around the nation, each presenting a balance of expert views. We cosponsor an annual retreat for members of Congress and a separate one for senior congressional legislative staff, dealing with health matters. We consult with reporters, editorial writers and producers across the country on health policy debates in Washington and how they affect local citizens. The Alliance also has published a series of highly regarded guides for journalists on covering health issues. You are reading the latest edition.

Our underlying goal – from our origin and into the future – is affordable, quality health care and long-term care for all Americans. The enactment of the Affordable Care Act in 2010 has changed the context and content of our educational offerings for opinion leaders, but not our aim.

We are at the beginning of what promises to be a lengthy period of adjustment to the health reform law, a period that will see continuing delivery system innovation and more vigorous efforts to prevent disease, improve the quality of care and gain greater value for each health care dollar spent.

These changes will occur in ways that reflect, and in some cases go beyond, the changes made in the new law. We will continue to pursue our mission during this period by:

- explaining the myriad provisions of the law, and their policy implications;
- examining how various aspects of the law are being carried out, at both federal and state levels;
- tracking how well the law is achieving its objectives in coverage, cost and quality;
- looking at proposed changes in the law, as unintended consequences and "unfinished business" emerge over time;
- exploring new trends and initiatives in prevention; and
- presenting new ideas in care delivery, wherever they are occurring, that are noteworthy for their positive effects on quality, cost-efficiency and health outcomes across the continuum of care and across populations.

FIND-AN-EXPERT SERVICE FOR REPORTERS

The service is a quick way for those involved in news production to find experts in 36 major health policy topics and more than 200 subtopics.

Those using the service can narrow searches to experts who:

- Live in a particular state or media market
- Take after-hours calls from reporters
- Can put reporters in contact with "real people"
- Have b-roll for television
- Can conduct interviews in Spanish or another language other than English.

More than 500 experts have signed up, from across the political spectrum and from across the nation. If you're a working reporter, editorial writer, producer or otherwise involved in news production, we invite you to register at www.allhealth.org/ed/rptrreg.asp.

If you've already registered, please go to www.allhealth.org/ed/reporterlogin.asp to do a search. Whenever you're on deadline and don't have time to do a search, call the Alliance at 202/789-2300 and we will help you find an expert.

LOCAL STORIES ON HEALTH ISSUES

The online version of this book (www.allhealth.org/sourcebooktoc.asp?SBID=5) features local news stories related to the topic of each chapter. We update these stories regularly to spotlight promising story ideas for a wider media audience, and to acknowledge reporters who are going the extra mile to inform their readers, listeners and viewers about vital health topics that often are not easy to explain in lay terms.

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CHAPTER 1

HEALTH REFORM

Originally written by Joanne Kenen, New America Foundation, and updated by Joanne Kenen and Deanna Okrent, Alliance for Health Reform.

FAST FACTS

- The health care reform law enacted in March 2010 will reduce the number of uninsured nonelderly people by an estimated 32 million.[1] As a result of the reform law, 94 percent of nonelderly citizens and legal residents are expected to have coverage by 2019.[2]
- Some 23 million nonelderly people will remain uninsured by 2021, according to the Congressional Budget Office (CBO).[3]
- As of 2009, 50.7 million nonelderly people in the U.S. lacked health coverage, up from 46.3 million in 2008, according to the U.S. Census Bureau.[4]
- Nearly 80 percent of the uninsured in 2009 lived in families headed by workers.[5]
- In 2009, 18.1 percent of full-time employees and 28.7 percent of part-time employees age 18-64 were uninsured all year.[6]
- An estimated $2.5 trillion was spent on health care in the United States in 2009, nearly 17.3 percent of the Gross Domestic Product (GDP).[7]
- Health care reform is expected by CBO to save $124 billion over 10 years, and bring down the federal budget deficit by about one-half percent of GDP in the next decade.[8]
- CBO's preliminary analysis indicates that repealing the Patient Protection and Affordable Care Act would increase federal budget deficits by about $230 billion in the period 2012 to 2021.[9]
- The United States lags behind other industrial nations in many health care quality indicators.[10]

See p. 9 for story ideas and p. 11 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=117

BACKGROUND

National health reform efforts have surfaced and resurfaced in the United States for over a century. But before 2010, none had garnered enough popular support and congressional support to enact a federal law that came anywhere near the goal of universal coverage.

What was different in 2009-2010? Did the economy, the burgeoning federal deficit, the aging of the population, the obesity epidemic, its consequent chronic diseases, and the development of high tech medicine cause double digit increases in health care costs and inspire health reform? Or did the political climate and a new president placing a high priority on health care issues start the proverbial ball rolling?

In any case, we can begin a new health reform story on March 23, 2010, when President Barack Obama signed the Patient Protection and Affordable Care Act into law. (The law is commonly referred to as the Affordable Care Act or ACA.)

The legislation, which will result in an estimated 32 million uninsured Americans getting health coverage by 2019, will begin to redesign a fragmented, uncoordinated and highly expensive health care system. The new law was the fulfillment of a goal sought by reformers, with varying degrees of intensity, since Theodore Roosevelt introduced the idea of coverage for all in the 1912 Progressive Platform.

As President Obama noted, it was a "remarkable and improbable" achievement.[11] Yet in our current polarized environment, it remains fraught with political and policy uncertainties that could shadow, even threaten, implementation in the years to come.

Historically, our discussions of national health reform focused on coverage. This time, the case was made that health reform is greater than coverage alone. Coverage, cost and quality, reform proponents argued, are intrinsically entwined, and cannot be addressed by piecemeal or incremental solutions.

Our system, rooted in a mid-20th century acute care model, does not adequately meet the health care or economic needs of the 21st century, where the overarching medical challenge, and expense, flows from chronic disease in an aging population.[12]

Reform proponents argued that the cost of inaction outweighed the cost of action,[13] and that state and federal governments, large and small businesses, and ordinary American families needed relief from the unrelenting and unsustainable upward march of health care costs.[14] They convinced a majority of lawmakers, albeit a narrow Democrats-only majority, that covering the uninsured in a revamped and modernized high quality health care system is the morally and fiscally responsible path forward.

Health care reform is difficult because it's big and complicated, with lots of moving parts and unintended consequences. It affects more than one-sixth of the economy, and touches every doctor, hospital, and community. It's also hard because even in less volatile political times, Washington debates are not always about health care per se, but about politics, power, and the size and reach of government. It is because of these factors that the debate goes on well after passage of the law.

The results of the midterm election in November 2010 may move the debate in another direction. The nation and the Congress are divided over health reform. Public opinion polls show a country closely divided between those in favor and those opposed to the law.[15,16]

Republicans in Congress pledge to repeal parts or all of the law, or starve the remaining unfunded provisions of the law. In January 2011, the Republican majority in the House of Representatives voted to repeal the ACA entirely. (The repeal bill failed in the Democrat-controlled Senate.)

Although action on repeal would face a presidential veto as long as Obama is president, the level of uncertainty about the ultimate fate of reform has been raised. U.S. District Court judges in Virginia and Florida have ruled that the individual mandate is unconstitutional. Three other District Court judges, in Virginia, Michigan, and the District of Columbia, ruled that the mandate meets constitutional requirements.[17] It is expected that the case will ultimately come before the Supreme Court.

IMPLEMENTATION

The 18 months of debate and the opening phase of implementation were shaped by an interesting paradox. As Professor Robert Blendon of the Harvard School of Public Health has explained, many in the U.S. are skeptical about "health reform" but support many of reform's components, such as creating health insurance exchanges, subsidizing the poor, or requiring insurers to cover people with pre-existing conditions.[18]

Reform's success in the long term will be determined in part by whether and when the American public decides that health reform is the sum of its reasonably popular parts and how well implementation proceeds.

The federal government and the states have a shared role in implementation. Federal agencies have responsibilities ranging from direct implementation of some provisions in the law to discretionary decision-making with regard to other provisions. The implementation timeline set forth in the ACA required the Department of Health and Human Services and the other regulatory agencies to move quickly, especially on provisions scheduled to be implemented in 2010 and 2011.

States also have had to move quickly on their options with regard to implementing high risk pools and designing health insurance exchanges. At the same time they are dealing with budgetary challenges, legislative calendars, and administrative transitions resulting from the November 2010 elections. (For more detail see Alliance issue brief, "Implementing Health Reform: Federal Rules and State Roles," at http://goo.gl/8XyEG.)

Stakeholders – physicians, hospitals, insurers, employers and consumers, to name just a few – will also be affected by how the law is put into effect. Many are actively engaged in the process, in rulemaking on the federal level and in their state politics.

COVERAGE

As noted, the health care reform law will result in coverage for an anticipated 32 million Americans and legal immigrants – 16 million through the biggest-ever expansion of Medicaid.[19] The percentage of insured nonelderly residents (excluding illegal immigrants) is expected to increase from 83 percent in 2011 to 95 percent in 2021.[20] About 23 million nonelderly residents (close to one fourth of whom are undocumented immigrants[21]) will remain uninsured.

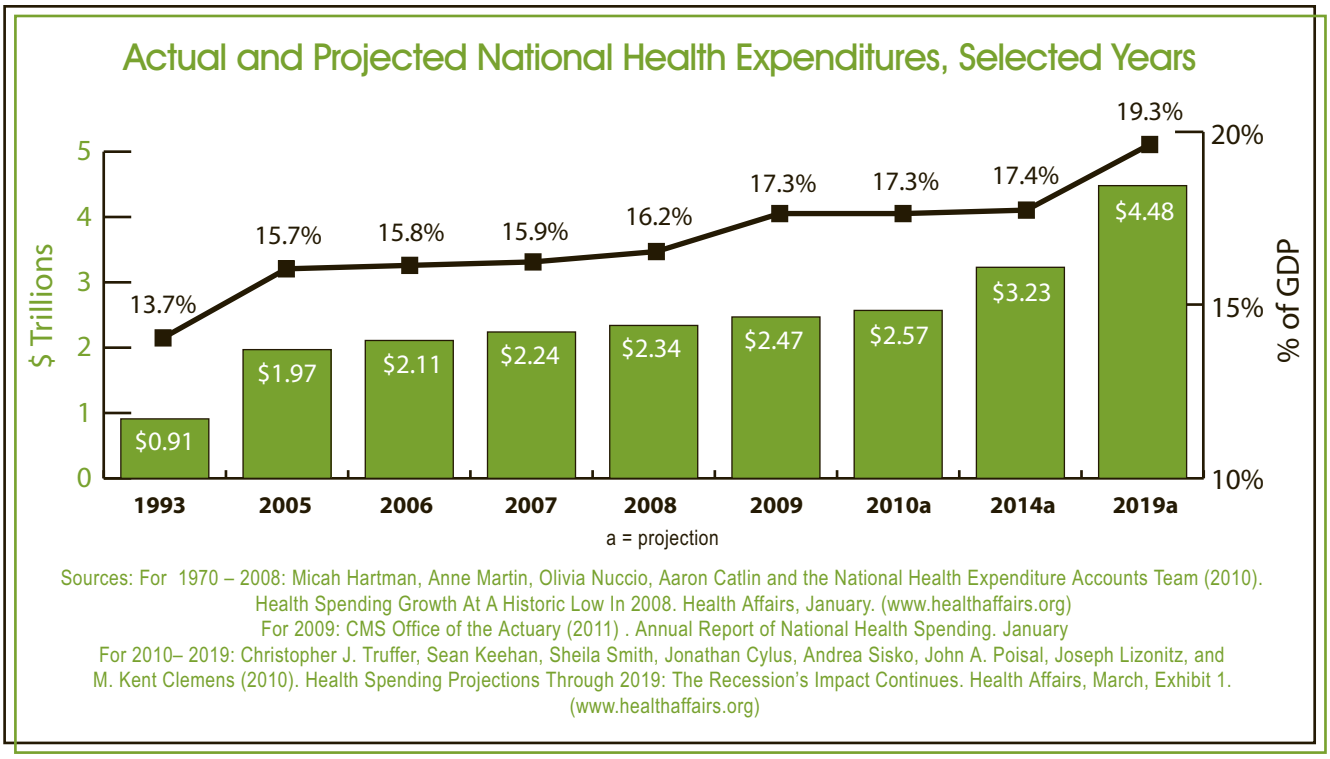
Although only Democrats voted for the final legislation, the bill itself was an amalgam of ideas from both parties. The individual mandate, for instance, was initially a Republican idea that came to prominence during President George H.W. Bush's administration.[22]

The new health care law is a hybrid of public and private solutions. It maintains the current employer-based system but fills in the gaps by expanding public programs, notably Medicaid, and devotes more resources ($11 billion from FY 2010-15) to community health clinics.[23] It creates "exchanges" or purchasing pools starting in 2014 to help individuals and small business purchase affordable and reliable coverage.[24]

The state-based exchanges, which according to the Congressional Budget Office will cover about 23 million people by 2021[25], will have to follow new rules and will provide new consumer protections.[26] (Not everyone who will be covered in the exchanges is currently uninsured, nor will all individuals in the exchange be subsidized. Undocumented immigrants will not be allowed to buy plans within the exchanges.)

Insurers will have to cover everyone, including people with pre-existing health conditions. They won't be able to charge a higher premium based solely on a person's health status.[27] There will be limits on how much individuals and families will have to pay out of pocket in any year, and plans will include better coverage for preventive care. (Other consumer protections come into play earlier.) (For more details on the exchanges and the new regulatory framework, see the Kaiser Family Foundation's summary at http://goo.gl/ZjeU9).

The health reform law calls for shared responsibility – government, individuals and businesses all have obligations. People who do not buy insurance, or businesses that do not cover their workers, will face penalties. Small businesses and low-income individuals



will receive subsidies, and there will be some exemptions based on affordability. People can get subsidies on a sliding scale up to 400 percent of the federal poverty level. (See the chapter on the costs of health care for details on coverage levels and subsidies.) (For more details, go to http://goo.gl/ZjeU9.)

In addition, the legislation contains the CLASS Act (Community Living Services and Supports Act), which establishes a form of limited government-backed long-term care insurance. Participation in the program is voluntary. The benefit will not cover all long-term care costs, but will provide a cash benefit which can be applied to at-home assistance for the elderly or persons with disabilities who need help with routine daily activities such as eating, bathing or other long-term care services. The law expands and creates several other initiatives aimed at providing community-based, rather than institutional care of the elderly and persons with disabilities. (See Chapter 9, "Long-Term Care," for more.)

The health reform law gradually closes the "doughnut hole" or coverage gap in the Medicare prescription drug benefit,[28] expands preventive care coverage in Medicare (and Medicaid), and covers annual physicals and wellness visits for Medicare beneficiaries.[29]

COST AND FINANCING

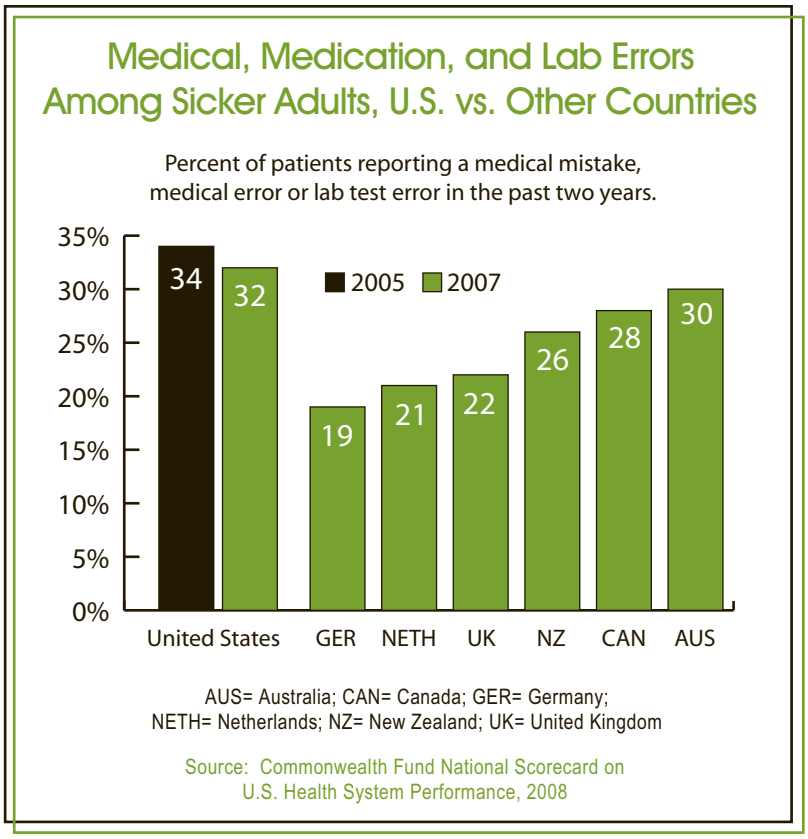
The nearly $1 trillion coverage expansion will be funded in part by higher Medicare payroll taxes on upper income families, excise taxes on so-called "Cadillac" health insurance policies, and fees paid by pharmaceutical companies, hospitals and insurers. Payments to Medicare Advantage, the private Medicare plans, will be restructured to eliminate overpayment.

Constraining health care spending was part of the health reform debate from the very beginning. (See chart, "Actual and Projected Health Spending for Selected Years, 1993 - 2019.") The biggest anticipated savings in the reform law come from cuts to health care provider payments under Medicare, Medicaid and the Children's Health Insurance Program.[30] Some of the projected savings will come from "delivery system" reforms and changed payment incentives. These involve strategies to shift the health care system to some extent away from its acute care orientation, and more toward care of patients with chronic disease, which is responsible for 78 percent of our national health expenditures.[31]

The legislation includes numerous incentives, pilot projects, demonstrations and experiments designed to

create a more integrated and coordinated system, while simultaneously improving quality and restraining cost growth. New tools include medical homes, Accountable Care Organizations, and bundled payments for episodes of care. (See the "Quality" section below and Chapter 3, "Quality of Care.")

One of the new cost containment tools will be the Independent Payment Advisory Board, which will make Medicare payment and waste-reduction recommendations to Congress (although hospitals are exempt through 2019). Another is the new Center for Medicare and Medicaid Innovation, which will allow new patient-centered care models to be tested, recalibrated, and introduced system-wide with more speed and flexibility than traditional demonstration projects.[32]



In addition, the legislation creates a pathway for approval of biogenerics (drugs based on biologically active substances), steps to strengthen the primary care workforce, and a new Patient-Centered Outcomes Research Institute to oversee federally sponsored comparative effectiveness research to determine which drugs, devices or procedures work best.[33] (See Chapter 2, "Cost of Health Care.")

QUALITY AND ACCESS

We all have heard the statement that the United States has the best health care in the world. We can no longer take this for granted. (See chart, "Medical, Medication, and Lab Errors Among Sicker Adults, U.S. vs. Other Countries.") Our health care markers in several areas lag behind other industrialized nations, even though we spend much more per capita and a higher percentage of our GDP.[34]

A 2010 survey of 11 countries by The Commonwealth Fund found that one-third of U.S. adults went without recommended care, did not see a doctor when sick, or failed to fill prescriptions because of costs. This compared with as few as 5 percent of adults in the United Kingdom and 6 percent in the Netherlands. The U.S. ranked last among the group of eleven countries on this dimension.[35]

Another example in which the U.S. lags behind many other countries lies in access to primary care when sick. Only 57 percent of adults in the U.S. saw their doctor the same or next day when they were sick, compared with 70 percent of U.K. adults, 72 percent of Dutch adults, 78 percent of New Zealand adults, and 93 percent of Swiss adults.[36]

In the last few years, the dialogue about health care quality has begun to change in Washington. More experts have concluded that we need to shift resources and priorities into primary care, care coordination, prevention and wellness.[37] The health reform legislation begins to do this, by experimenting with new ways of paying doctors and hospitals, rewarding care management and coordination, and beginning to shift the system to reward quality, not quantity. (See Chapter 3, "Quality of Care," for details.)

Many of these provisions in the legislation are modest steps or experiments, focused on government-run programs like Medicare and Medicaid, and it is not clear

Four Common Causes of Chronic Disease

Four modifiable health risk behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for much of the illness, suffering, and early death related to chronic diseases.

- More than one-third of all adults do not meet recommendations for aerobic physical activity based on the 2008 Physical Activity Guidelines for Americans, and 23 percent report no leisure-time physical activity at all in the preceding month.
- In 2007, less than 22 percent of high school students and only 24 percent of adults reported eating 5 or more servings of fruits and vegetables per day.
- More than 43 million American adults (approximately 1 in 5) smoke.
- In 2007, 20 percent of high school students in the United States were current cigarette smokers.
- About 30 percent of adult current drinkers report binge drinking (consuming 4 or more drinks on an occasion for women, 5 or more drinks on an occasion for men) in the past 30 days.
- Nearly 45 percent of high school students report consuming alcohol in the past 30 days, and over 60 percent of those who drink report binge drinking (consuming 5 or more drinks on an occasion) within the past 30 days.

Source: Centers for Disease Control and Prevention."Chronic Disease Prevention and Health Promotion." Downloaded on June 7, 2010. (www.cdc.gov/chronicdisease/overview/index.htm)

how quickly or powerfully they will ripple through the whole health care system. The law, however, requires the adoption of a national quality improvement strategy, which includes wellness and population health, as well as a new effort to document and address health care disparities. (See the quality chapter for more information.)

Among the tools that aim at creating a high performing health system:

CHRONIC DISEASE MANAGEMENT, MEDICAL HOMES AND ACCOUNTABLE CARE ORGANIZATIONS

The Centers for Disease Control and Prevention (CDC) estimates that 133 million Americans live with one or more chronic diseases such as hypertension, diabetes or asthma. CDC also estimates that chronic disease accounts for 70 percent of U.S. deaths[38] and more than 75 percent of health care costs.[39] (See text box, "Four Common Causes of Chronic Disease.")

The health reform law encourages the development of "medical homes" where doctors are paid to manage and monitor chronic diseases, and while medical homes may be part of the solution, more research is still needed.[40] (See chapter 3, "Quality of Care", for more information.)

The legislation also encourages Accountable Care Organizations, encompassing new relationships between primary and specialty care doctors and hospitals. Using a more integrated and evidence-based approach to care, providers will have to meet quality benchmarks but can share in savings from Medicare or Medicaid. (See chapter 3, "Quality of Care", for more information.)

WORKFORCE/PRIMARY CARE

Delivery system reform is looking to primary care as an important factor in the quality, value, cost-saving equation. To expand access to primary care services, the health reform law improves Medicare and Medicaid primary care reimbursements (although the legislation specifies these improvements only for the next five years in Medicare and only for 2013 and 2014 in Medicaid). The law also contains other incentives, including a reallocation of Graduate Medical Education residency training slots to encourage medical students to pursue careers in primary care and general surgery.

However, these measures may not be sufficient to alleviate what some analysts consider to be a critical shortage in the primary care physician workforce. Many point to how long it takes to train physicians, how few graduates are choosing primary care and where physicians choose to practice. The latter can cause shortages through maldistribution of the workforce.

Some argue that nurse practitioners can meet part of the primary care demand.[41] Nurse practitioners are registered nurses with master's or doctoral degrees and advanced clinical training. The legislation ex-

pands education, training and loan support for nurses and nurse practitioners. It also includes pilot programs that rely on team-based care and an expanded role for advance practice nurses and physician assistants.

Such models could result in the more efficient use of the health care workforce and extend the reach of primary care providers. Successful programs can be expanded at the discretion of the secretary of health and human services.

An October 2010 report by the Institute of Medicine recommended that nurses be allowed to practice to the full extent of their education and training. It suggested that the federal government might promote reform of states' scope of practice laws by sharing and providing incentives for the adoption of best practices.[42]

The ACA also contains many workforce provisions beyond those that support and encourage primary care. For example, it establishes grants for staff training and other patient protection and quality improvements for nursing home and other long-term care facilities.[43]

PAYMENT REFORM

The legislation contains financial incentives for hospitals to reduce unnecessary readmissions and bring down rates of hospital-acquired infections and related conditions. It authorizes tests of bundling, or paying a team of providers for one episode of care across several health care settings in a way that rewards quality, coordination of care among providers and outcomes.[44] It creates Community-based Collaborative Care Network Programs which aim to improve chronic disease treatment and management in outpatient settings.

HEALTH INFORMATION TECHNOLOGY

Physicians have been slow to embrace health information technology (IT) and most still write prescriptions on paper, though the trend among office-based physicians to adopt electronic medical records or electronic health records (EMR/EHR) has been increasing.
The National Center for Health Statistics revealed that in two 2009 surveys, 21.8 percent of physicians reported having a basic system and about 6.9 percent reported having a fully functional system. The estimates for 2010 are 24.9 percent and 10.1 percent respectively.[45] Preliminary estimates for 2010 showed over 50 percent of physicians reported using all or partial EMR/EHR systems, up from 48 percent in 2009.

Barriers to wider adoption include cost, debates over who should pay, worries about obsolescence, steep learning curve, concerns over maintaining patient privacy and lack of interoperability among health IT systems.[46]

The American Recovery and Reinvestment Act of 2009 pledged almost $20 billion in government funding to assist and incentivize "meaningful use" of health IT. The Centers for Medicare & Medicaid Services (CMS) priorities for "meaningful use" of IT include improving the quality, safety and efficiency of health care, reducing disparities and improving public health, improving care coordination and engaging patients, and ensuring privacy protections for personal health information.[47]

The ACA provides additional support for health IT, requiring the development of national standards for the management of data collection, interoperability among health IT systems and security systems for data management.[48]

In the public health arena, large pools of privacy-protected data could lead to early identification of epidemics or bioterrorism, and help comparative effectiveness research.

PUBLIC HEALTH

Employers and states are putting new emphasis on wellness and prevention, particularly regarding obesity, exercise, tobacco use and diabetes prevention and management. (See Chapter 12, "Public Health," for more.) The health legislation allows more leeway for employers to link workplace wellness to insurance premiums.

The public has gained increased awareness of the childhood obesity epidemic thanks to the attention of First Lady Michelle Obama. The health reform law appropriates $25 million for CMS to carry out, during FY2010 – FY2014, the Childhood Obesity Dem-

onstration Project enacted as part of the Children's Health Insurance Program Reauthorization Act of 2009.[49]

The law also establishes a National Prevention, Health Promotion, and Public Health Council within the Department of Health and Human Services (HHS), chaired by the U.S. surgeon general. The role of the council is to coordinate leadership on prevention, wellness, and health promotion policies and activities across federal agencies and to develop a national strategy that sets specific goals and objectives for improving population health.

Bioterrorism legislation since the September 11 attacks has helped modernize the public health infrastructure in ways that enhance emergency preparedness for either a natural epidemic or a bioterrorist attack. The reform legislation provides grants to help public health agencies improve surveillance of infectious diseases and other public health problems, and respond to these threats.[50]

Public health researchers have stepped up efforts to understand and address the persistent and sometimes perplexing racial and socioeconomic disparities in our health care system, and the health reform law encourages further work in this area. (See Chapter 10, "Disparities," for more.)

THE UNKNOWNS AND THE UNRESOLVED

Health reform represents a massive change. Some of the forecasts about its effects are educated guesses based on models and assumptions – assumptions about economics, health and the future actions of politicians as well as health care providers. Concerns remain, in particular, about whether competition, regulation and administrative simplification in the state insurance exchanges will make insurance affordable for the middle and lower-middle class.

Health reform, and its implementation, is also a work in progress. Congress takes up some aspect of Medicare, Medicaid or health policy almost every year. Sometimes it's a small tweak to payment formulas. Sometimes it's a sea change, like covering AIDS drugs or providing Medicare to the disabled, or covering poor children under the Children's Health Insurance Program.

The 2010 reform legislation will need tweaks, adjustments, and possibly over time, major amendments. States too will continue to experiment on their own. Some insurers and health plans may resist change; others may find their economic self-interest and the health interests of the population they serve coincide.

This assumes that efforts to repeal the law continue to be unsuccessful and that appropriations for various provisions are forthcoming. Though repeal is considered unlikely by many policy analysts, given the number of votes needed to override a presidential veto, the efforts will take much energy and possibly critical funding away from fully implementing the ACA.

In addition, the United States faces deep deficits for years to come. The health sector is unlikely to be off limits to a national debt-reduction strategy. Lawmakers pondered, and discarded, dozens of potential revenue raisers for health reform, ranging from taxes on sugary soft drinks to sweeping changes to the tax code.[51] Expect to see many of these ideas resurface in a new context as the nation grapples with its deficit and debt.

In December 2010, the bipartisan deficit commission appointed by the president issued a report and recommendations that addressed health care spending in a number of areas.[52] The commission recommended first reforming both the formula for physician payments (known as the Sustainable Growth Rate or SGR) and the CLASS Act, and finding savings throughout the health care system to offset the costs of those reforms.

With regard to physician payment, the commission recommends replacing the reductions scheduled under the current formula with a freeze through 2013 and a 1 percent cut in 2014. It also recommends that CMS develop an improved physician payment formula that encourages care coordination across multiple providers and settings and pays doctors based on quality instead of quantity of services. This recommendation supports other provisions in the law that

relate to reforming the delivery system. It remains to be seen what Congress will do when the current physician payment schedule expires late in 2011.

TIPS FOR REPORTERS

- A common error is equating universal health care with government-run or socialized medicine. They aren't the same thing, even if some politicians claim they are. Socialized medicine means that hospitals are owned by the government, and most health providers are government employees. Universal health care simply means that everybody is covered: whether in a public system, a private system, or as is the case under U.S. health reform, a public-private hybrid.[53]
- More health care does not always equal better health care. Get familiar with the basic ideas of the Dartmouth Atlas of Health Care (www.dartmouthatlas.org). In more than 30 years of work, Dartmouth researchers have discovered huge differences in how people are cared for in different parts of the country. Regions that spend more on very sick people do not necessarily have better outcomes. In fact, lower-spending regions often show better results, partly because they tend to use more primary care and proportionately fewer specialists.[54]
- Health policy as an academic field has grown tremendously since the early 1980s, in and outside of Washington. And nowadays it's all online, which makes the Washington think tanks more accessible to regional reporters. In addition, journalists can now tap into expertise in health or public policy departments at local universities. These academic experts can both help translate national policy and explain the impact of national proposals on a specific region or state.
- Almost every story can be a health care story. Whether a reporter is covering a labor dispute, the local economy, personal bankruptcy, local politics or early childhood well-being, health care can nearly always be part of the picture.
- More clinicians and provider groups have begun to encourage health care improvements on a local scale. Identify innovators in your community through organizations such as the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement and the American Academy of Family Physicians. Learn through your local hospitals and medical associations which providers are taking part in national pilot and demonstration programs, and which health plans may be backing innovation in the private sector too.
- Find out what's unique about your state's health care system. Many states and governors are testing their own approaches to more affordable coverage and more integrated or evidence-based delivery of care. The State Coverage Initiatives program, sponsored by the Robert Wood Johnson Foundation and administered by AcademyHealth in Washington, DC, keeps tabs on reforms at the state level (www.statecoverage.org). The National Academy for State Health Policy is another useful resource (http://www.nashp.org/).
- The Association of Health Care Journalists (www.healthjournalism.org) has links to many resources, webcasts, and tip sheets of use to reporters covering reform.

STORY IDEAS

- How is your state participating in the implementation of health reform? Has your state's legislature passed any companion laws, named a health reform commission, staffed up their department of health and human services or other relevant state agency in preparation for changes due to reform? Is your state challenging the health reform law through the courts and, if so, what does that mean for citizens seeking health coverage?
- What decision has your state made about a health insurance exchange as to what type it will be, who will run it and which health plans will be able to sell their products through it? Is your state seeking a Medical Loss Ratio waiver?
- Does your community have a primary care shortage? How easy is it to get a primary care doctor? What is your state or community doing to encourage more doctors to go into primary care? Understand the role of primary care providers as care coordinators, not necessarily as HMO-style gatekeepers.

- "Medical homes" are appearing in numerous communities. A definition from the American Academy of Pediatrics: "Primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective."[55] Are there medical homes in your community? If so, what do they look like? How can patients access them? What is it like to be a patient in one of them? Is this a genuine innovation or new name for primary care?
- Spend some time with local medical students. How much do they know about the health care system that they are entering? What fields of medicine interest them as a career? What factors influence their choice of residency or specialization? Where do they hope to practice and why? How much debt do they have resulting from their educational path?
- Your local emergency room is a barometer for the health of your community's medical system. Is it crowded? If so, it may be not only because of the growing numbers of uninsured. Explore how much of the overcrowding in your community is due to lack of insurance, how much is caused by the inability of the insured to access timely primary care (including nights and weekends). How much is due to internal management and patient flow problems within the hospital? If your ER isn't crowded, what are they doing right? How are people getting appropriate community-based care?
- The Centers for Medicare & Medicaid Services, the federal government's Medicare agency, introduced "never event" payment rules, meaning they won't pay for certain avoidable conditions such as wrong-site surgery or certain hospital-acquired infections.[56] Some states and private insurers are introducing similar policies. This isn't expected to radically change payments to hospitals in the early years, but it is designed to make hospitals take a hard look at how they can improve quality. How do hospitals in your community stack up? How have they responded to the new policy? Is your state requiring hospital to do more reporting on mistakes or hospital-acquired conditions including infections?
- Many large employers have introduced workplace wellness and prevention programs. Are they working? Are they cost-effective? Do they discriminate against people who have chronic conditions?
- Community health clinics have taken on an expanded role in covering the poor and the uninsured, and this will grow in the coming years. The new reform law includes major new funding for these clinics. Quality varies; some clinics are actually de facto medical homes, which do a good job of providing primary care, coordinating chronic disease, and linking patients to needed social services in the community. How do your local clinics stack up?[57]
- The health reform law will result in an increase of about 16 million new Medicaid beneficiaries. Medicaid is already a significant share of many state budgets. Will states be able to shoulder this new burden? What cuts is your state making to Medicaid benefits, or considering? What is the current level of poverty that qualifies one for Medicaid in your state? Will the new national standard, 133 percent of the federal poverty level, be higher or lower than your state's current qualifying level?
- High-risk pools authorized and funded by the ACA are intended for people who have been denied health insurance coverage due to a pre-existing condition. Officially called the Pre-Existing Condition Insurance Plan (PCIP), this is a temporary measure until 2014 when insurers will no longer be able to deny coverage due to pre-existing conditions and health insurance exchanges will make it easier for individuals to buy coverage. Did your state have its own high-risk pool before health reform? Who is running the ACA-funded high risk pool– the state or HHS? How many people have enrolled? Why aren't more eligible people enrolling in the program? Is the cost of the insurance unaffordable?
- More and more physicians across the country are changing to electronic health records, though the rate of uptake varies from region to region. Are physicians in your community using paper or electronic records? Are these physicians in

single, double or large group practices? If they are not converting to electronic records, why not? If they have converted, how has it changed their practice?

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CHAPTER 2

COST OF HEALTH CARE

Originally written by Meena Seshamani, M.D., Ph.D., Johns Hopkins University School of Medicine, and updated by Len Nichols, Ph.D., George Mason University, and by Bill Erwin, Alliance for Health Reform.

FAST FACTS

- The United States spent $2.5 trillion on health care in 2009, or $8,086 per person. This amounted to 17.6 percent of the nation's gross domestic product (GDP).[1]
- Health care costs more than tripled from 1990 to 2009[2] and are projected to rise to 19.6 percent of GDP in 2019.[3]
- The average cost of an employer-based family insurance policy in 2010 was $13,770, close to the annual earnings of a full-time minimum wage job.[4] Premiums for employer-sponsored family health coverage more than doubled from 2000 to 2010.[5]
- Since 1998, per capita health spending has grown an average of 2.2 percentage points faster than per capita GDP.[6]
- The exclusion of employer health premium contributions from employee taxable income is the nation's largest tax expenditure, totaling a projected $177 billion in federal revenue passed up in FY2011.[7]
- The United States spends more per capita on health care than any other nation in the 40-country Organization for Economic Co-operation and Development (OECD). OECD countries – most of which are developed nations – spent an average of about 9 percent on gross domestic product on health expenditures in 2008. The U.S spent 16 percent of GDP. Next closest was France at 11.2 percent.[8]
- The Patient Protection and Affordable Care Act of 2010 (or ACA, for short) supports pilot testing of several new provider payment mechanisms that could help constrain spending, including Accountable Care Organizations, patient-centered medical homes and bundled payments.[9]
- The ACA also establishes a new Independent Payment Advisory Board whose charge is to recommend specific Medicare cost saving techniques to the Congress if expected cost growth targets are not hit.[10]

See p. 23 for story ideas and p. 24 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=118

BACKGROUND

Americans, given our variety of political viewpoints, differ on many things when it comes to health policy issues. But there is wide agreement on at least one thing: the current growth rate in health care costs is unsustainable.

President Barack Obama, even as a presidential candidate, pointed to health care costs as a primary reason to pursue health reform. The Republican "Pledge to America" issued in 2010 says: "The American people wanted one thing out of health care reform: lower costs…." [11] The National Association of Manufacturers website says the rising cost of health benefits "is threatening the ability of manufacturers to create jobs and compete in the global economy."[12]

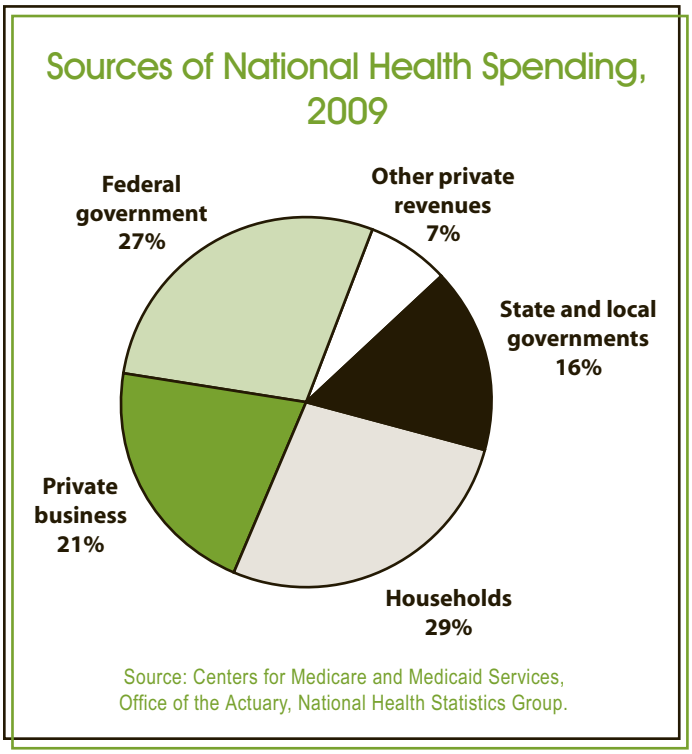
Lowering costs would be a hollow victory, however, if quality of care were to go down along with the costs. Thus, much attention has been given to ways of enhancing quality and efficiency of care, and thus gaining more value for the health care dollars spent. (For more on this subject, see the quality chapter.)

In 2009, $2.5 trillion was spent on health care in the U.S., an average of $8,086 per person. The federal government estimates that health care costs more than tripled from 1990 to 2009 (not adjusted for inflation).[13]

Health care spending constituted 17.6 percent of the gross domestic product (GDP) in 2009[14] and is projected to rise to 19.6 percent of GDP in 2019.[15] Princeton University economist Uwe Reinhardt notes that at the current rate of increase, health spending could make up more than 40 percent of GDP by 2050.[16]

Medicare and Medicaid together, which made up 6.2 percent of GDP in 2009,[17] are expected to equal 8.4 percent in 2019, making health spending a major force behind rising federal spending and projected deficits in the coming years (and an obvious target for addressing budget imbalances).[18]

Spending by federal, state and local governments accounts for 43 percent of overall health spending. Spending by households makes up 29 percent of the total, while spending by private business accounts for 21 percent and other private spending equals 7 percent. (See chart, "Sources of National Health Spending, 2009.")[19]

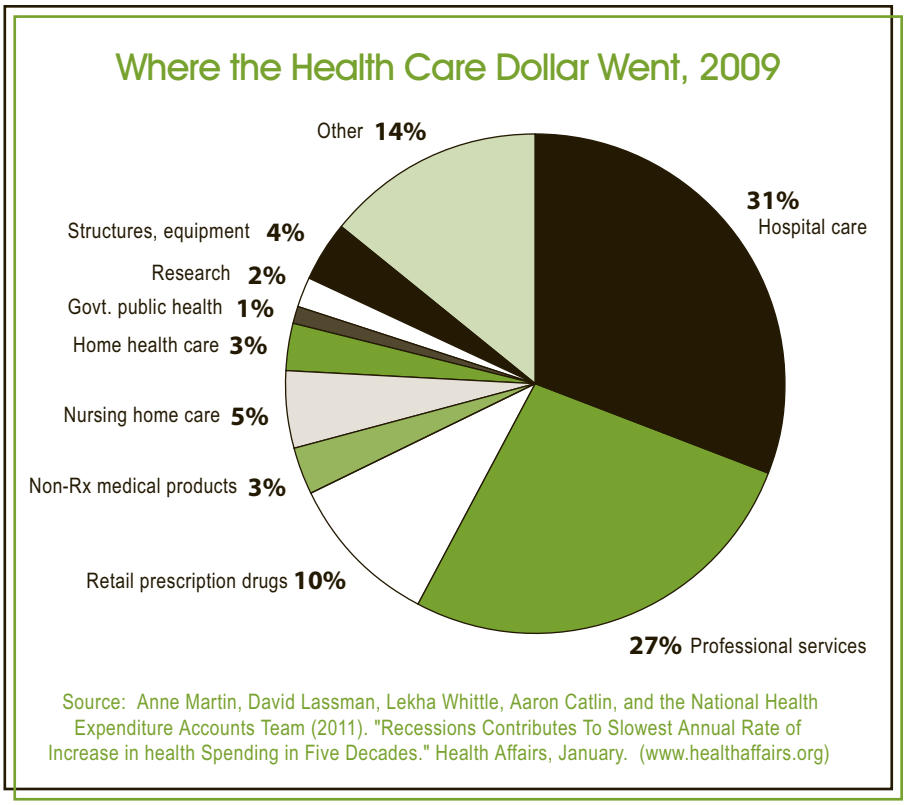


Federal spending on Medicare would be reduced by $48 billion per year, according to the Government Accountability Office, if fraudulent or improper payments were eliminated. This is more than 9 percent of the $509 billion that the government spent on Medicare in FY 2010.[20]

For every $100 spent on health care, $30.50 goes to hospitals, another $27 to professional services (including physicians and dentists), $10 to prescription drugs bought at retail, $5.50 to nursing care facilities and continuing care retirement communities and $2.75 to home care.[21] (See chart, "Where the Health Care Dollar Went in 2009.")

Health spending in the U.S. stands above that in other developed countries, both per capita and as a percent of GDP. The United States spends more per capita on health care than any other nation in the 40-country Organization for Economic Co-operation and Development (OECD).[22] Health costs per capita have also grown faster here than in other countries since 1980.[23]

What is driving our unsustainable rate of increase in costs? Most analysts agree that new technologies and services, as well as greater use of existing technologies, are the primary reasons.[24] This is not necessarily bad, since we are better at fixing hips and hearts than we were 30 years ago. But by a large margin, we are getting far less health value – quality care per dollar spent – than other countries,[25,26] and so the quest for greater effectiveness and efficiency is intensifying.



Other cost growth drivers include a relative rise in health service prices vs. general inflation,[27] partly due to consolidation and local market power among hospitals, physician groups, and insurers.[28] In addition, worsening health status (particularly obesity), a high proportion of specialists in a region, and low productivity gains in the health care sector generally contribute to cost increases.[29]

Reduced cost sharing and malpractice are often cited as major cost drivers. (Cost-sharing involves out-of-pocket spending by consumers for insurance deductibles, coinsurance, copayments, and premium contributions – see glossary for definitions.) But cost sharing fell far more rapidly in the U.S. between 1960 and 1990 than it has since; excess cost growth (over GDP growth) has been remarkably constant. Furthermore, cost sharing has been increasing within employer sponsored insurance – still the largest type of insurance in the U.S. – since 2000, as employers have shifted more and more costs to workers in order to stem premium increases.[30]

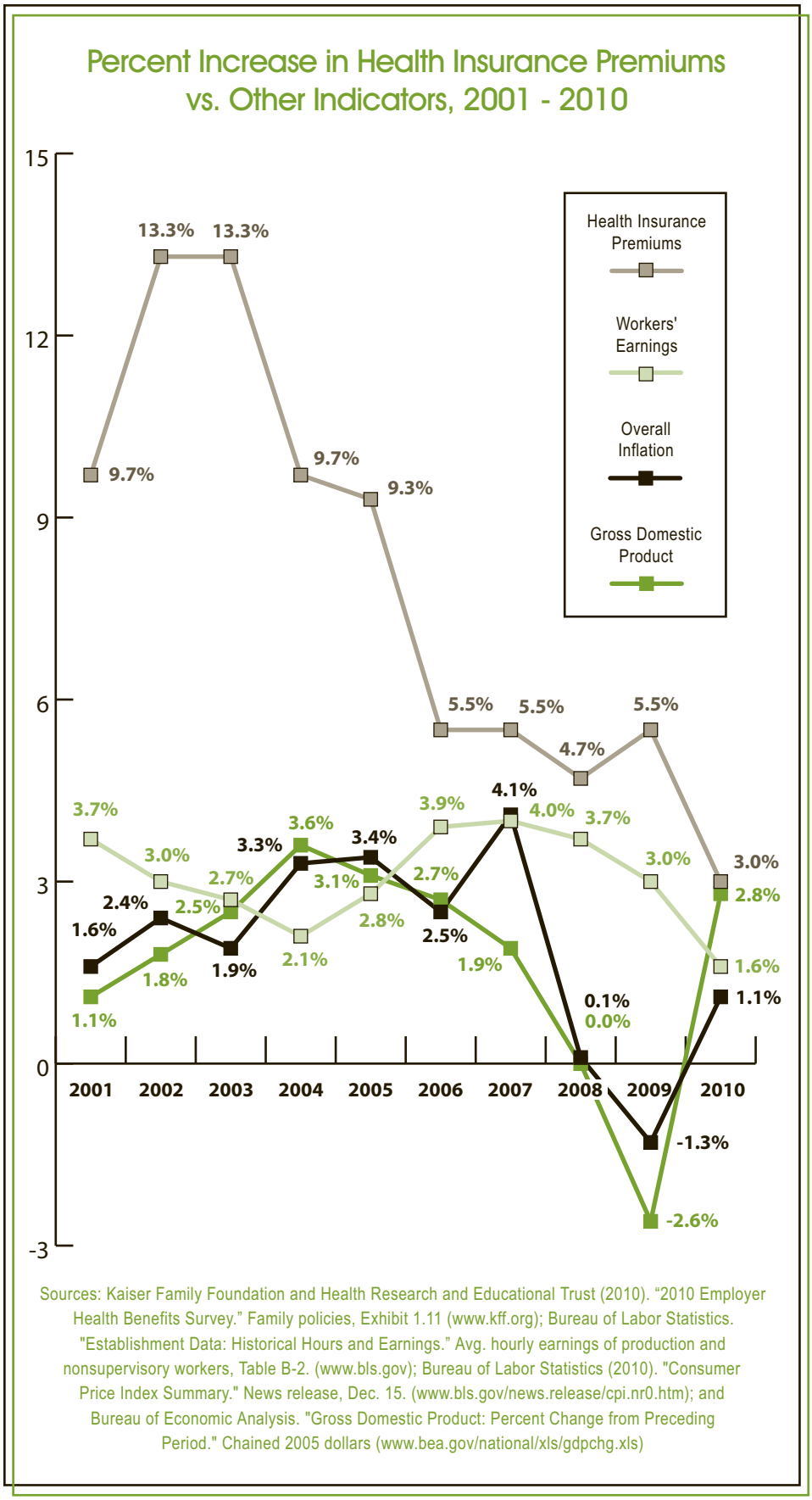
Most analysts also conclude that defensive medicine induced by fears of malpractice suits does not contribute much to cost growth.[31] The malpractice system should be reformed, most agree, but the largest gain from this will be more justice for patients and less unnecessary fear among clinicians, not lower costs.[32]

The elderly account for a disproportionate amount of health care spending, with nearly half of lifetime expenditures per capita occurring after age 64.[33] Women age 65 and older account for a greater portion of spending than men, since women on average live longer than men.[34] But population aging plays only a minor role in explaining health cost increases over time.[35]

CONSEQUENCES OF RISING COSTS

The rise in health care costs has affected the health and financial well-being of individuals and families, and the fiscal futures of employers and governments. Especially during the recent recession, health care costs have been a source of stress for private sector employers. Some major U.S. automakers, for example, note that they spend more on health care than on steel for their cars.[36, 37]

The average cost of an employer-based family insurance policy in 2010 was $13,770,[38] close to the annual earnings of a full-time minimum wage job. Premiums for employer-sponsored family health coverage more than doubled from 2000 to 2010,[39] and increased faster than other economic indicators (See chart, "Percent Increase in Health Insurance Premiums vs. Other Indicators, 2001 – 2010.")



Sources: Kaiser Family Foundation and Health Research and Educational Trust (2010). "2010 Employer Health Benefits Survey." Family policies, Exhibit 1.11 (www.kff.org); Bureau of Labor Statistics. "Establishment Data: Historical Hours and Earnings." Avg. hourly earnings of production and nonsupervisory workers, Table B-2. (www.bls.gov); Bureau of Labor Statistics (2010). "Consumer Price Index Summary." News release, Dec. 15. (www.bls.gov/news.release/cpi.nr0.htm); and Bureau of Economic Analysis. "Gross Domestic Product: Percent Change from Preceding Period." Chained 2005 dollars (www.bea.gov/national/xls/gdpchg.xls)

Likewise, employees and self-employed individuals have been feeling the pinch. Almost a third of respondents in a December 2010 poll by the Kaiser Family Foundation said they or another household member had put off getting needed health care because of cost concerns. One out of five respondents said they had had a serious problem paying for health care and health insurance as a result of the recession.[40]

The amounts that workers pay for their coverage have far outpaced inflation. In 2000, workers paid an average of $135 monthly for family coverage and $28 for single coverage. By 2010, those amounts had grown to $333 (up 147 percent) and $75 (a 168 percent rise).[41] Inflation over that period amounted to 27 percent.[42]

Employers compensate for rising health care costs in part by keeping a lid on wages. One study estimates that an employer's expenses for health benefits are offset by a 9 percent reduction in wages.[43]

LIKELY POLICY DEBATES

As health care costs continue to place pressure on both public and private insurers, debates revolving around the Patient Protection and Affordable Care Act of 2010 (ACA, for short) and entitlement reform will surely in-

volve ways to constrain costs. Some of the methods tried or proposed include:

INCREASED COST SHARING

As health care costs have risen, employers and public programs have shifted costs to consumers.

By increasing the amount of out-of-pocket contributions from patients, cost sharing can increase patient cost awareness in health care decision making, providing an incentive to pursue cost-efficient treatments. One example of this effect is tiered copayments for prescriptions, which give consumers an economic incentive to select generic medications rather than brand name drugs.

CONSUMER-DIRECTED HEALTH PLANS

Making patients more aware of costs is also the reasoning behind consumer-directed health plans (CDHPs), which link a high-deductible health plan with a tax-sheltered health reimbursement account (HRA) or health savings account (HSA). (See glossary for definitions.) Patients make out-of-pocket health care payments from their HRA or HSA until they have reached their yearly deductible amount, at which point their health plan starts picking up expenses.

Enrollment in such plans is growing steadily. A survey of large employers by the Mercer company found that in 2010, 11 percent of all covered employees were in consumer-directed health plans, up from 9 percent in 2009. Enrollment in such plans has risen by two percentage points yearly since 2006.[44]

One reason for this growth may be lower premiums. A report from the Employee Benefit Research Institute notes an average savings of 4.8 percent in premiums for CDHPs compared to other types of health plans, due in part to younger, healthier workers choosing CDHPs.[45]

CHANGES IN PROVIDER REIMBURSEMENT

Many methods have been tried to reduce payments to providers as a way of reining in health care costs. Medicare is moving toward pay-for-performance reimbursement, whereby a specified percentage of a hospital's payment would be based on performance measures, ranging from giving smoking cessation advice to administering antibiotics immediately before, during and after surgery.[46]

Payers can also cut costs by simply decreasing the amounts they pay providers. Medicare's Sustainable Growth Rate (SGR) policy is supposed to do this, aiming to keep total spending for physician services in Medicare Part B under a defined target figure.[47] The Balanced Budget Act of 1997 significantly cut Medicare reimbursements to providers. Similarly, several states have reduced or frozen Medicaid reimbursement rates in response to budget shortfalls.[48] In the private sector, insurance companies try to negotiate lower rates.

However, each of these policies can have unintended consequences. Providers may (and do) drop patients who are in lower-paying insurance plans, or refuse to accept them in the first place.[49] Congress has repeatedly restored the physician payment cuts mandated by the Sustainable Growth Rate without implementing other ways to achieve the targeted savings.[50] Cutbacks to hospitals may decrease the quantity of services provided and adversely affect patient outcomes.[51, 52, 53]

For these and other reasons, current payment reform discussions are less about price cuts and more about changing the structure of provider payment, toward more global payments for value, i.e., paying for a large group of related services and for longer periods of time, and making the full payment only if quality, efficiency and patient satisfaction targets are all met.

The Affordable Care Act includes a number of pilot programs that test payment reforms. The ACA also signals a new approach to payment by reducing what the Medicare Payment Assessment Commission has concluded are overpayments to Medicare Advantage plans relative to the costs of their enrollees,[54,55] and by reducing Medicare's formerly automatic market basket update payments to hospitals.

Among the new payment models included in the ACA, and that many analysts think are most promising for development and testing across various locales and payers, are:[56]

- **Accountable care organizations (ACOs)** – Although the federal government had not yet fixed the definition of an ACO when this book went to print, these entities are certain to align the financial incentives of hospitals and physicians and are likely to assume full responsibility for the health of a defined patient population.
- **Patient-centered medical homes** – Medical homes represent a team approach to the ambulatory management of the chronically ill, combining the insights of physicians, non-physicians and patients themselves (or their advocates). Medical homes, in conjunction with cooperating specialists and hospitals, could reduce unnecessary hospitalizations and emergency department use and also share in the savings from doing so.
- **Bundled payments** – By linking the financial interests of hospitals and other providers, bundled payments would provide powerful incentives for the coordination of care across settings.
- **Independent Payment Advisory Board** – This group's charge is to recommend specific Medicare cost saving techniques to the Congress if expected cost growth targets are not hit. Members will be appointed by the president and confirmed by the Senate. In an unprecedented delegation of authority, the board's recommendations will take effect automatically unless Congress substitutes other techniques that the Medicare actuary thinks would be equally effective.
- **"Cadillac tax"** – The excise tax on high-cost health insurance plans (the so-called "Cadillac tax") sends a very clear signal to the private sector that failure to get serious about cost growth containing in the long run will result in substantial penalties for employers, workers and insurers.

HEALTH INFORMATION TECHNOLOGY

Substantial financial support for health information technology (IT) expansion occurred early in the 111th Congress. Electronic medical records can result in improved coordination of care among health care providers, reduce medical errors, and enable easier, standardized measurement of health care cost and quality. Moreover, improved clinical decision support for providers could decrease variability in the use of health care services.

But whether health IT can save substantial sums is as yet unanswered.

CHRONIC DISEASE MANAGEMENT

Much of today's cost growth has been due to chronic conditions such as diabetes, arthritis, hypertension and kidney disease.[57] Therefore, the prevention of chronic disease, and the improved, coordinated management of chronic disease once it develops, are critical to providing more cost-efficient, high quality care.

But disease-management has had mixed results as a cost-containment tool so far. Eight pilot programs conducted by Medicare did not reduce costs, largely because the sickest and most vulnerable (and thus most costly) patients were less likely to agree to participate in disease-management efforts.[58] Other studies have shown that efforts at preventing and dealing with chronic diseases typically add to health care spending, rather than reducing it. A review of 1,500 interventions for prevention and treatment found that about 20 percent did lower costs. The rest added more costs than they saved.[59]

PHARMACEUTICALS

Expenditures for prescription drugs at the retail level made up 10 percent of overall health spending in 2009.[60] Drug spending increased 5.3 percent in 2009, according to the Centers for Medicare and Medicaid Services. This was an acceleration from the 4.7 percent growth in 2007 and 3.1 percent in 2008.[61]

This acceleration is occurring as brand name drugs face increased competition from generics and insurers are aggressively using tiered formularies (which require consumers to pay less out-of-pocket for generics than for brand name drugs). The federal government estimates prescription drugs spending will grow by an average of 6.1 percent a year from 2009-2019.[62]

Some suggest the following ways that government might lower drug costs:

- using the large market share of the elderly population in Medicare to negotiate lower prices with pharmaceutical companies,

- allowing importation of medications from other countries where they are cheaper, or
- revising patent laws to allow generics to be brought to the market sooner.

Pharmaceutical companies challenge all of these methods. Estimates of savings from government price negotiations are modest.[63] Safety questions arise with imported drugs. Another general concern is that pharmaceutical profits provide the needed capital and incentive for research and development. In 2002, 82 percent of the investment by global pharmaceutical companies was spent in the United States, and pharmaceutical companies employ over 223,000 American workers.[64]

TIPS FOR REPORTERS

- Consideration of health care quality and outcomes goes hand-in-hand with issues of health care costs.
- Consider all of the various players in looking at health care costs. This includes health care providers, patients, payers, government, employers (large and small), employees and health insurance plans. Each will have different interests and will be affected differently by policy changes.
- The financial effects of health care policy should be considered in both the short and long term; a short-term investment may lead to long-term cost savings.
- The way health care is financed can affect the way health care is provided. New financing mechanisms in the health reform law, such as bundling payments to providers, and cutbacks, such as to hospitals and Medicare Advantage plans, could change health care delivery in dramatic ways, for better or worse.

STORY IDEAS

- Contact local employers, both small and large, and find out if they believe the Affordable Care Act is affecting their costs, either up or down.
- See what your local hospitals and physicians think about new payment methods contained in the Affordable Care Act, such as bundled payments. Check out the Prometheus payment model (www.prometheuspayment.org).
- Find out what kinds of changes local employers have made to their health plans in terms of increased cost sharing (copayments, deductibles), alternative plan structures such as Health Savings Accounts, or dropping coverage. What do they consider to be the pros and cons of each option? How have employees reacted to such changes?
- Interview providers about whether the level of cost-consciousness in health care has changed in recent years, among providers and among patients. What kinds of efforts have been made by providers to incorporate cost in management decisions?
- Many hospitals and physician offices have adopted new health information technologies. Are any of these technologies saving money yet? Or only adding to expenses?
- Interview local hospital officials to find out what utilization management or education programs have been implemented – or are under consideration – to try to make health care delivery more cost-efficient. This could include an examination of physician practices compared to their peers, programs to prevent medical errors and complications, and health prevention.
- Interview employers as to what employee wellness, educational or health utilization programs they have implemented to try to rein in health care costs. Have they found these programs to make a difference? How have employees responded to them?
- Contact local government officials and find out what the challenges they face in covering Medicaid patients and administering public health programs. What measures have been taken to manage the costs? How are the effects of the recession affecting funding for public health programs?
- What cost-containment lessons are being learned in reform-oriented states, such as Massachusetts and Vermont? For instance, a Vermont law en-

acted in May 2010 caps hospital budget increases. How is this working out?

- Contact administrators at local health insurance plans to find out which areas have generated high costs and what efforts have been made to streamline care in those areas. Examples could include efforts to move away from care provided in the emergency room setting toward primary care office visits; wellness and prevention programs; and incentive structures for providers.
- Conduct a round-table discussion or focus group with members of the community to discuss rising health care costs. What do they think are the causes? Would higher co-payments and deductibles make them more cost conscious in their decisions? Would it lead them to not access care? What are areas to target?

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CHAPTER

QUALITY OF CARE

Originally written by Richard Sorian, National Committee for Quality Assurance, and updated by Richard Sorian and by Kevin Arts, Alliance for Health Reform.

FAST FACTS

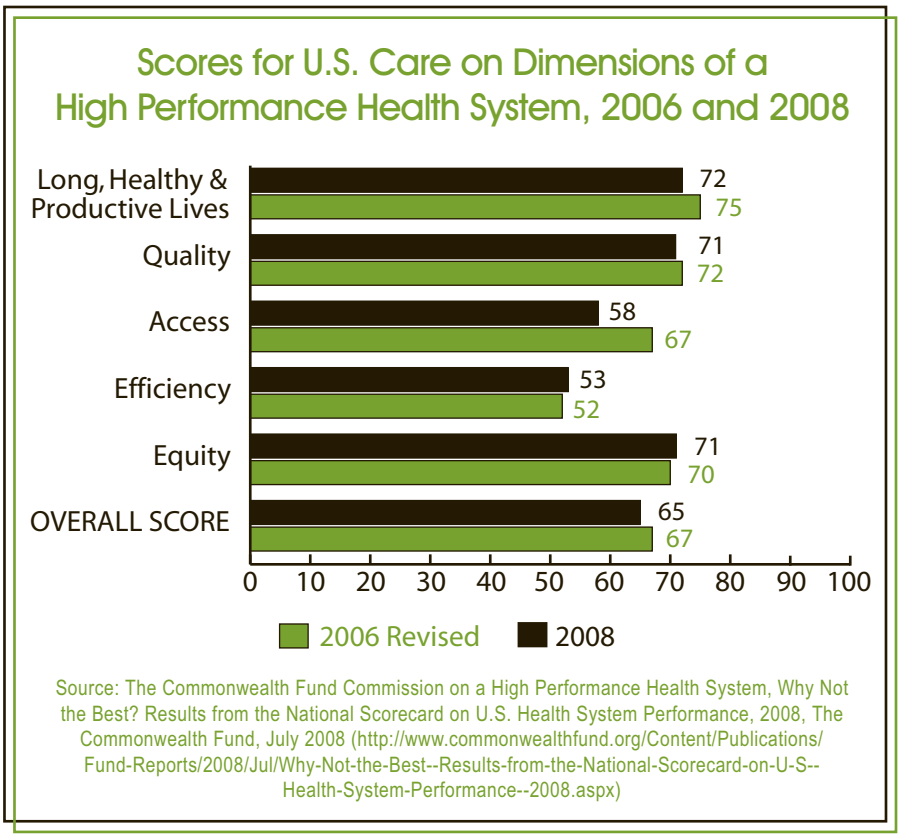
- In a ranking of 19 industrialized countries, the U.S. had the highest number of unnecessary deaths.[1]
- Among 37 nations, the U.S ranks 29th in terms of infant mortality with nearly twice as many infant deaths per capita as France.[2]
- Americans receive recommended evidence-based care, on average, 55 percent of the time. Women are more likely than men, and those age 18 - 30 are more likely than those age 65 and older, to get the care recommended.[3]
- Hospital-acquired infections harmed 1.7 million people in the U.S. in 2002.[4]
- Estimates of the annual direct medical costs of health care-associated infections to U.S. hospitals range from $28.4 billion to $45 billion.[5]
- Variations in the quality of care do not seem to be linked to how much we spend on health care.[6]
- The goal of most quality measurement is to improve health care services by monitoring and analyzing data and, based on what the data indicate, changing practices to improve performance.[7, 8]
- Evidence shows that the release of quality data annually over a period of years stimulates improvement in the measured areas.[9, 10]
- The health reform law enacted in 2010 builds on previous law to encourage quality improvements in myriad ways.

See p. 37 for story ideas and p. 38 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=119

BACKGROUND

The American health care system is often lauded for its first-rate surgical centers, innovative technologies and groundbreaking medical research. But it is by no means perfect.

Study after study has identified significant concerns with the quality of care delivered to Americans. In a landmark 2001 report, "Crossing the Quality Chasm," the federally chartered Institute of Medicine (IOM) said, "The performance of the health care system varies considerably. It may be exemplary, but often is not, and millions of Americans fail to receive effective care."[11] (See chart, "Scores for U.S. on Dimensions of a High Performance Health System, 2006 and 2008.)



Source: The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, The Commonwealth Fund, July 2008 (http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Jul/Why-Not-the-Best--Results-from-the-National-Scorecard-on-U-S--Health-System-Performance--2008.aspx)

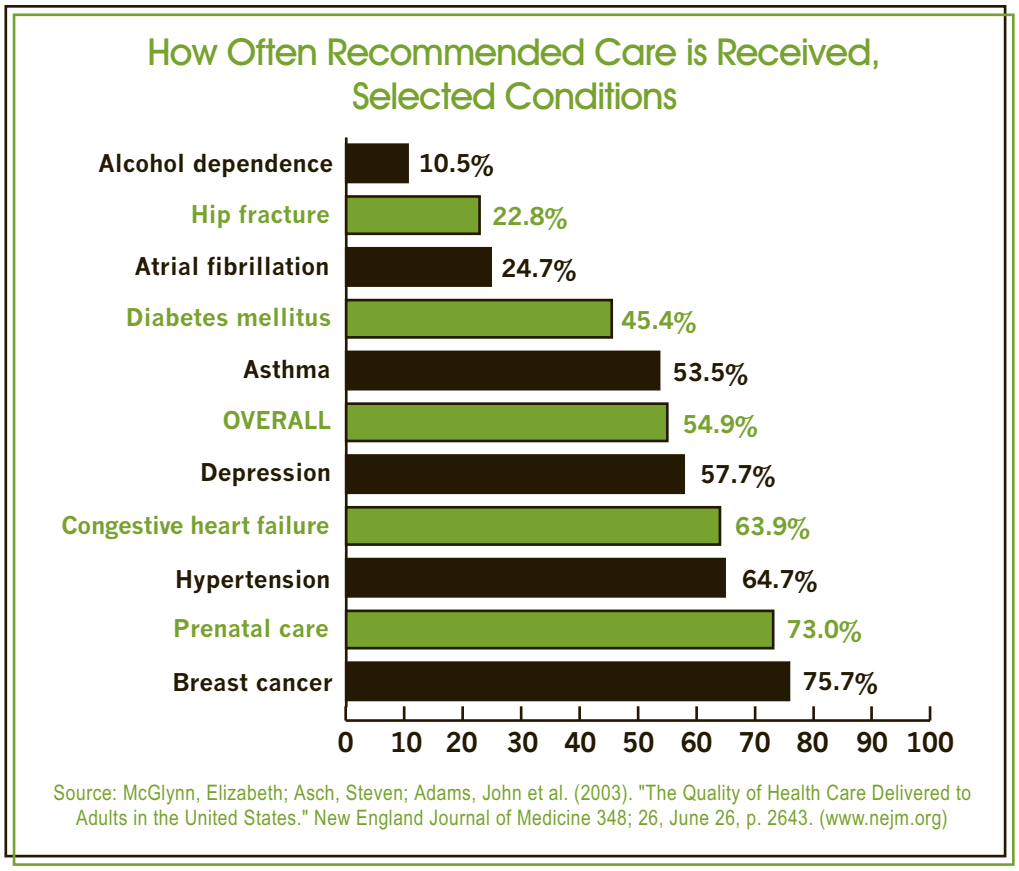
Indeed, the IOM report estimated that between 44,000 and 98,000 people die in U.S. hospitals each year as a result of preventable medical errors.[12] Since then, a major investigative project by Hearst Newspapers concluded that the number could have risen to as high as 200,000 deaths per year.[13] A recent government study found that 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays, costing the Medicare program an estimated $4.4 billion in FY 2009.[14]

Americans receive recommended evidence-based care, on average, only 55 percent of the time, with significant variability according to the specific condition.[15] (See chart, "How Often Recommended Care is Received, Selected Conditions.") There are more surgical and medical mishaps per capita in the U.S. than in Germany, the United Kingdom, Canada or the Netherlands.[16] (See chart, "Deaths Due to Surgical or Medical Mishaps per 100,000 Population, 2007.")

The IOM defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[17] This vision calls for care that is safe, effective, patient-centered, timely, efficient and equitable (i.e., does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status).[18]

The IOM and other experts often put quality problems into three major categories:[19]

- Underuse occurs when patients do not get care that is medically indicated. An example is the failure to use commonly available screening tests for every patient who could benefit from them.
- Overuse occurs when patients receive care that is not medically indicated. Typical examples are use of antibiotics to treat a cold or the use of imaging devices for someone with the first signs of lower back pain.
- Misuse describes care that is provided poorly or erroneously, such as wrong-site surgery.[20] Support for efforts to measure and improve quality has grown rapidly as purchasers and consumer advocates sought information about the underly-



ing value of the health care services for which they were paying an ever-increasing price.

HOW CAN WE IMPROVE QUALITY

Quality improvement is the result of measurement, reporting and action. Health care organizations and practitioners often compare their internal measurement results to national or regional benchmarks and make necessary adjustments. (For more information on quality measurement, please see text box, "Quality Measurement.")

Public release of performance information in the form of report cards, online databases and other means can be a powerful driver for improvement. Evidence shows that when data are released annually over many years, it stimulates improvement in the measured areas.[21]

Many employers and other purchasers of health care coverage use quality measurement results to guide their choices of plans and providers. State insurance regulators and administrators of such public programs as Medicare and Medicaid often encourage or require hospitals, HMOs, nursing homes and others to report quality information.

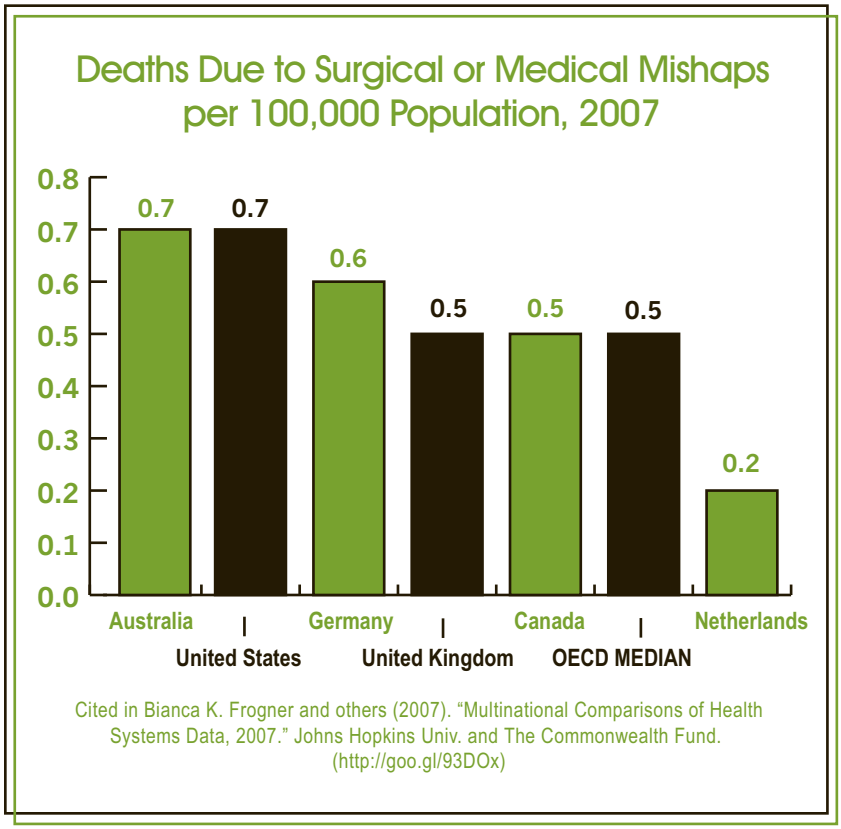
The Robert Wood Johnson Foundation is engaged in a national effort to improve the quality of care, called Aligning Forces for Quality (AF4Q). The program sponsors community-based quality initiatives in 15 states and 253 counties, encompassing 12.5 percent of the U.S. population. These initiatives are focused on three areas: performance measurement and public reporting, consumer engagement and quality improvement.[22] It is the largest effort of its kind by a U.S. philanthropy.

Several public initiatives have been developed from the Aligning Forces model, including the Agency for Healthcare Research and Quality's Chartered Value Exchange project and the Office of the National Coordinator's Beacon Community program.[23]

PAY FOR PERFORMANCE

In recent years, public and private sector leaders have been experimenting with ways to incentivize quality improvement. Often lumped under the rubric "pay for performance" or "P4P," these include financial bonuses and positive publicity for high-quality providers, while retaining the basic fee-for-service payment structure.

Much of the momentum for P4P has come from the private sector. Bridges to Excellence, for instance, is a nonprofit, employer-driven initiative that recognizes physicians for making changes that achieve better outcomes for patients. [24, 25, 26] It focuses on areas with a deep history of measurement: diabetes care, cardiovascular care, and patient self-management systems.



Participating physicians receive bonus payments and are highlighted in provider directories, helping employees and their families make informed choices.[27] Results are encouraging.[28]

For more information on pay for performance, see the online version of this chapter at www.allhealth.org/sourcebookcontent.asp?CHID=119.

QUALITY PROVISIONS IN ARRA & CHIPRA

The Obama Administration and the 111th Congress began to tackle some of these quality issues in the American Recovery and Reinvestment Act (ARRA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA), both enacted in 2009.

ARRA invests some $20 billion to help physicians, hospitals and other providers obtain and use health information technology to improve health care quality and coordination of care. The Health Information Technology for Economic and Clinical Health (HITECH) Act directed the U.S. Department of Health and Human Services (HHS) to develop health information technology (IT) standards.
Physicians will be eligible for grants of $40,000 to $65,000 to purchase health IT that conforms with those standards, while hospitals can receive several million dollars each to make such purchases. Eventually, physicians and hospitals that do not have certified electronic health records will be penalized by Medicare and Medicaid.[29]

CHIPRA contains a series of provisions aimed at measuring and improving quality for children enrolled in the Children's Health Insurance Program (CHIP) and Medicaid. The law requires HHS to develop and publish a core set of quality measures for the care of children in either program, encourage standardized reporting by states, and improve and expand on the core measures over time.[30]

QUALITY PROVISIONS IN HEALTH REFORM

The Patient Protection and Affordable Care Act of 2010 (or ACA, for short) contains several significant provisions aimed at improving the quality of care in America.

A NATIONAL STRATEGY

Beginning in 2011, the HHS secretary is to develop an annually-updated national quality strategy, in consultation with various stakeholders convened by National Quality Forum (NQF) to set priorities.[31] Every three years, HHS will identify both improvements to existing measures and gaps where no quality measures exist. Federal funds of up to $75 million a year are authorized to support the development of measures in those areas.[32]

CENTER FOR MEDICARE AND MEDICAID INNOVATION

The ACA provides for the establishment of a Center for Medicare and Medicaid Innovation (CMMI), within the Centers for Medicare and Medicaid Services. This center is tasked with examining new ways to deliver and pay for health care in order to save money for Medicare and Medicaid and improve the

Quality Measurement

The first step to improving health care quality, most experts believe, is to measure performance – a concept initiated largely by employers in the 1980s.[1]

The most widely used set of quality measures is the Healthcare Effectiveness Data and Information Set (HEDIS), developed through an alliance between health care plans and employers and now overseen by the National Committee for Quality Assurance (NCQA).[2]

HEDIS has spawned a number of other measuring tools that are used to assess care in a variety of settings. These include patient experience metrics, such as the H-CAHPS and C/G-CAPHS, as well as measures of cost and efficiency.[3]

In 1999, the National Quality Forum (NQF) was created to sort through existing quality measures and to endorse those that have the most relevance to purchasers, providers and consumers.[4] Administrators of the Medicare program, in particular, have turned to the non-profit NQF to help them choose which measures should be adopted.[5]

In 2009, the U.S. Department of Health and Human Services awarded a contract to the NQF to help establish a portfolio of quality and efficiency measures that will assess federal health care spending.[6] The Affordable Care Act, enacted in March 2010, envisions broader roles for the NQF as government programs seek to measure results to determine payment for a variety of providers.

1 Steven M. Asch, Eve Kerr, Joan Keesey, et al. (2006). "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" New Eng land Journal of Medicine. March 16, 354(11):1147-56. http://goo.gl/HWoBS
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6 National Quality Forum. http://goo.gl/wZeFS

quality of health care outcomes. The ACA appropriates $10 billion to the CMMI to test such new care models as medical homes, patient safety initiatives and improved coordination of care for individuals eligible for both Medicare and Medicaid.[33]

COMPARATIVE EFFECTIVENESS RESEARCH

Building on provisions in ARRA, the health reform act establishes a nonprofit Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers and policy-makers in making informed health decisions, thereby improving patient safety and reducing medical errors. The institute will support research into the ways that diseases, disorders and other health conditions can be effectively prevented and dealt with. It will also synthesize existing research and disseminate findings to the public.[34]

The Agency for Healthcare Quality and Research houses a complementary initiative, the Center for Quality Improvement and Patient Safety, which is tasked with developing and propagating innovative strategies for quality improvement.[35]

The initiation of government-sponsored comparative effectiveness research was the subject of apprehension in parts of Congress and among key stakeholders.[36] Some worry that it will lead to rationing of care; others see promise in the concept.[37, 38] (For more information, see the text box on the debate over cost-effectiveness research. Also see the Alliance for Health Reform issue brief, "Comparative Effectiveness: Better Value for the Money?" and the Alliance - Robert Wood Johnson Foundation briefing on the same topic at http://goo.gl/t0jlR.)

PATIENT-CENTERED MEDICAL HOMES

Care is generally not well coordinated for the millions of Americans living with chronic diseases. Patient-centered medical homes correct this problem by allowing primary care practices to coordinate and integrate care across the health care continuum.[39, 40]

The ACA builds on the efforts of previous Congresses by:

- Authorizing states to offer a medical home option through their Medicaid programs,[41]
- Providing grants to states and other entities to establish community-based interdisciplinary teams to support primary care practices,[42] and
- Creating a new grant program to support training

Cost-Effectiveness Research

The issue of cost-effectiveness research produced some of the most heated debate in the national discussion preceding adoption of the ACA. Partly to address concerns that cost-effectiveness research would lead to rationing, the law stipulates that Medicare may not use cost-effectiveness metrics "as a threshold to determine coverage, reimbursement, or incentive programs."[1] However, some have interpreted this language as leaving open the possibility that cost-effectiveness research can be used to inform coverage and reimbursement decisions, so long as it is not the sole determinant and Medicare allows for public comment.[2] The scope and impact of comparative effectiveness research ultimately remain to be seen.

1 Health Affairs (2010). "Health Policy Brief: Updated: Comparative Effectiveness Research." Oct. 8. http://goo.gl/wIldF
2 MSNBC, Today Health (2010). "True or False: Top 7 health care fears." May 2. http://goo.gl/n8ug1

of primary care doctors to provide care through patient-centered medical homes.[43]

ACCOUNTABLE CARE ORGANIZATIONS

Another delivery system reform idea gaining attention is the Accountable Care Organization (ACO). An ACO is a health care provider structure designed to manage the full continuum of care and be responsible for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician–hospital organizations, multi-specialty practice groups with or without hospital ownership, independent practice associations and virtual interdependent networks of physician practices.[44]

Under the reform law, beginning in 2012, Medicare could contract for three years or more with ACOs that meet quality performance standards established by HHS and serve at least 5,000 Medicare beneficiaries.[45] HHS will establish performance standards to assess the quality of care furnished by ACOs and will set higher standards and new measures over time to drive quality improvement. Other provisions in the ACA create a Medicaid ACO demonstration project from 2012 to 2016.[46]

Early efforts are underway to form ACOs, though the assessment method and payment structure are still undetermined. Critics worry that certain payment methods, such as capitated payment, might lead to reduced treatment options for patients.[47] Also, some worry that the formation of ACOs will lead to undue market concentration, allowing these organizations to raise costs without improving quality.[48]

VALUE-BASED PURCHASING

Continuing and accelerating efforts begun during the second Bush Administration, the health reform law takes several steps to improve quality and safety in the Medicare program. These initiatives include:

- Making incentive payments to hospitals that meet certain performance standards, such as those focused on acute myocardial infarction.[49] HHS is charged with developing similar programs for skilled nursing facilities and home health agencies.[50]
- Changing the existing Physician Quality Reporting Initiative to begin penalizing physicians who do not report quality measures to CMS.[51] Similar changes are made to the quality reporting programs for hospices, long-term care hospitals and inpatient rehabilitation hospitals.[52] For more information, see the online version of this chapter at www.allhealth.org/sourcebookcontent.asp?CHID=119.
- Paying financial rewards to hospitals for reducing hospital-acquired infections and conditions.[53]
- Providing bonus payments to health plans participating in Medicare Advantage for high quality performance and improvement year to year.[54]

MEDICAID QUALITY

Building on provisions in CHIPRA, the health reform law makes new investments in improving the quality of care delivered to adult Medicaid beneficiaries.[55] Given that Medicaid enrollment is expected to increase significantly, these provisions could be important. They include:

- With stakeholder input, HHS published a list of core adult quality measures on December 30, 2010.[56] Updates to this core set will be published annually.
- By January 2012, HHS will create a Medicaid Quality Measurement Program to fund the development of quality measures in priority areas.
- By January 2013, HHS will develop a standardized format for reporting information based on the initial core set of adult health quality measures. It will also create procedures that encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

TIPS FOR REPORTERS

- Quality of care varies from community to community and often within a community. Find out how the quality in your community compares to national or regional benchmarks of care. How does the quality of care compare to the best (top 10 percent) of hospitals, health plans, and others?
- Get familiar with Hospital Compare (www.hospitalcompare.hhs.gov). This tool allows you to find out how well hospitals care for patients with certain medical conditions or surgical procedures, and view results from a survey of patients about the quality of care they received during a recent hospital stay.
- The source of measurement is as important as the results. Who developed the measurement tool? Were the results independently audited? Look for information from independent groups like the Joint Commission, the National Committee for Quality Assurance and such government sources as Hospital Compare.
- Check out the information about provider quality available to the public online, including the Aligning Forces for Quality community websites (http://goo.gl/nYlWQ)) and the Consumer Reports health ratings (http://www.consumerreports.org/health/home.htm). Are summary results provided in a friendly way?
- In 2010, the Centers for Medicare and Medicaid Services released Physician Compare (www.medicare.gov/find-a-doctor), a physician directory tool established by the Affordable Care Act. This directory contains practice quality measures. Find out if new quality ratings came out for physicians in your area. How do they measure up to nearby areas and to national standards?

STORY IDEAS

- How do employers in your area, especially large employers, use quality data to choose health plans and providers?
- Are providers in your area grouping into Accountable Care Organizations? If so, are they experiencing growing pains? What barriers must they overcome?
- How are providers in your area reacting to the health reform law's provisions supporting value-based purchasing?
- The quality of care delivered by health plans participating in Medicare Advantage varies widely. How do the plans in your community perform on the quality measures? Why is their performance so high/low? What are they doing to improve their performance?
- Are providers in your area taking part in a quality improvement effort or demonstration project? Examples include the CMS-led Physician Group Practice demonstration, the CMS/Premier, Inc. Hospital Quality Incentive Demonstration and the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative.
- If you have manufacturers of pharmaceuticals or medical devices in your area, what do they think of the comparative effectiveness movement? What outcome are they hoping for? What outcome are they expecting?
- Are health care providers in your area involved in pay-for-performance demonstration efforts? If so, do they think pay-for-performance efforts are fair? (An issue: Some providers, especially those serving low-income patients, think they should be rewarded for improvement in patient outcome, not solely for hitting certain benchmarks.)

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CHAPTER

EMPLOYER-SPONSORED HEALTH COVERAGE

Originally written by Paul Fronstin, Ph.D., Employee Benefit Research Institute, and updated by Paul Fronstin and by Bill Erwin, Alliance for Health Reform.

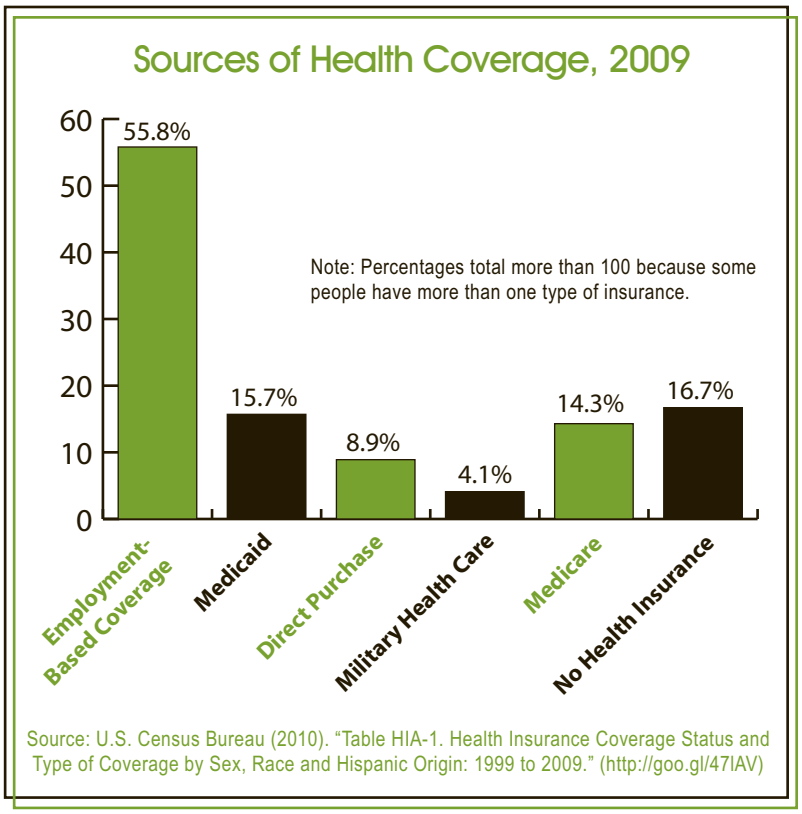
FAST FACTS

- 170 million individuals were covered by employment-based health benefits in 2009.[1] The percentage of individuals with such coverage was 55.8 percent in 2009, down from 58.5 percent in 2008.[2]
- The health reform legislation enacted in March 2010 is expected to result in a net reduction of about 100,000 in the number of people with employment-based coverage by 2019.[3]
- 68 percent of employers with 3 to 199 workers offered health benefits in 2010, up dramatically from 59 percent in 2009.[4] The health reform law provides subsidies to help certain small employers pay for their employees' coverage. The percentage of larger employers offering health benefits has held steady since 2000 at 98 to 99 percent.[5]
- 13.1 million individuals age 65 and older had some form of employment-based health benefits in 2009 – either as an active worker, retiree, or dependent.[6]
- Retiree coverage has been shrinking. In 2010, among employers with 200 or more workers that offered health coverage to active workers, 28 percent also offered health benefits to retirees, down from 35 percent in 2000 and 66 percent in 1988.[7]
- In 2010, premiums for employee-only coverage averaged $5,049 ($899 from the worker, $4,150 from the employer).[8] For family coverage, the average premium was $13,770 ($3,997 from the worker, $9,773 from the employer).[9]
- Workers paid an average of 19 percent of the total cost of employee-only coverage in 2010 (up two percentage points from 2009), and 30 percent for family coverage (up three percentage points from 2009).[10]
- For 2011, employers expect to hold their increase in health benefits costs to 6.4 percent by making changes to plan design or changing plan vendors.[11]

See p. 51 for story ideas and also for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=120

BACKGROUND

Health coverage on the job has long been the backbone of the U.S. health insurance system. About six out of every 10 individuals in the U.S. had some form of health insurance coverage through an employer in 2009.[12] (See chart, "Sources of Health Coverage, 2009.") This is a major contrast to most other developed countries, where people typically obtain coverage through government programs.



Source: U.S. Census Bureau (2010). "Table HIA-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1999 to 2009." (http://goo.gl/47IAV)

Most employers offering health plans contribute a hefty portion of the premium (82 percent on average for single coverage in 2010).[13] They do this because, in their view, there is a business case for doing so.[14]

These employers think that they must offer health benefits in order to recruit and retain workers in a competitive labor market. They also think that offering health benefits has a positive effect on worker health status and therefore on productivity (a proposition backed up by research).[15]

In addition, there are tax benefits for both employer and the employee. Health benefits are a tax-deductible expense for employers and they are excluded from taxable income to employees. This exclusion is the nation's largest tax expenditure, totaling a projected $177 billion in federal revenue passed up in FY 2011.[16] (Some small firms get an additional tax incentive through the Patient Protection and Affordable Care Act of 2010, discussed below.)

Overall, employer-sponsored health insurance is projected to pay 31 percent of the nation's total health care bill for 2009. This share is projected to shrink to 27 percent in 2019 if the Patient Protection and Affordable Care Act (ACA, for short) is implemented on schedule, as public funds pay for a greater portion of care.[17] (See details about the law below.)

Private sector employers contributed $397.5 billion toward employee and retiree health benefits in 2009, while federal, state and local governments contributed $150.2 billion. Individuals contributing to their own private coverage (predominantly employer-sponsored coverage) spent $247.6 billion.[18] The true cost for employees was actually higher, however. (See text box, "How Much Do Employees Really Contribute Toward Their Health Insurance?")

The number and percentage of people with employment-based health benefits has fallen considerably from the peak year of 2000. Almost 170 million individuals were covered by employment-based health benefits in 2009 – almost 10 million fewer than in 2000 and 6.6 million less than in 2008. The portion of the population covered through employment dropped to 55.8 percent in 2009, down from 58.5 percent a year earlier and 64.2 percent in 2000.[19] (See chart, "Trends in Employment-Based Coverage vs. Medicaid, 2000 – 2009.")

There are many varieties of employer-sponsored health coverage. Health maintenance organizations (HMOs) combine the functions of insurer and provider; members are typically required to select a primary care physician through whom all care must be coordinated. In preferred provider organizations (PPOs), a number of health care providers contract with one or more health plans to serve enrollees on a fee-for-

How Much Do Employees Really Contribute Toward Their Health Insurance?

In 2010, employees receiving health coverage through their employer paid 19 percent of the total premium out-of-pocket for single (employee only) coverage and 30 percent of the total premium for family coverage.[1]

But employees' true contribution toward their premium is actually higher. Studies have found that employers offering health coverage, consciously or not, pay less in cash wages to help pay for workers' coverage.

One study estimates that an employer's expenses for health benefits are offset by a 9 percent reduction in wages.[2] The study's authors, Patricia Ketsche and William Custer of Georgia State University, conclude that "Wages adjust downward at firms offering health insurance."

Another study found that in firms offering health coverage, obese employees are paid significantly less than employees of normal weight doing the same jobs. The authors' conclusion: employers expect obese workers to have higher health care costs. Since employers are prohibited from charging some employees more for coverage than others, they compensate by paying obese employees less.[3] For obese women, but not obese men, the wage reduction was more than the employer's expected increase in health costs.[4]

And even though employees' contribution to their premiums has remained relatively stable, that coverage has gotten much less affordable for lower-income employees. Families' premiums have risen so much that employer-sponsored coverage is now less affordable for families at 300 percent of the federal poverty level (FPL) than it was for families at 200 percent of FPL in 1999.[5]

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service basis at discounted fees. See the glossary for details.

ADVANTAGES AND DISADVANTAGES OF EMPLOYMENT-BASED COVERAGE

It is generally cheaper for a worker to receive the same covered services through employment-based benefits than to shop for coverage on his or her own. An employer, representing many workers, naturally has more clout in negotiating prices with insurers than any individual. Insuring a group of employees also represents less overhead cost per person for insurers than insuring an individual.

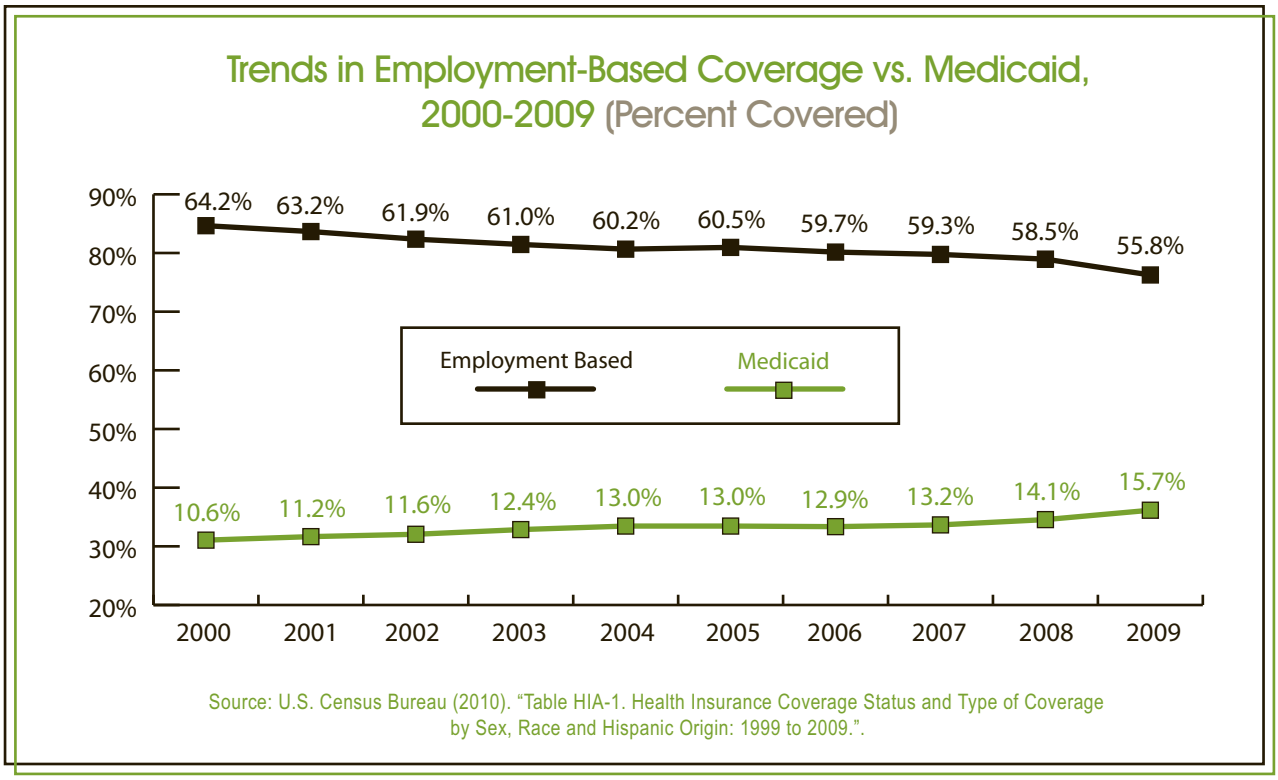
Buying coverage for a group of workers spreads the insurer's financial risk. Most people in the group will have minimal medical expenses, balancing the small number who will need expensive care. This generally leads to lower insurance rates for groups. (And of course, the same risk sharing helps lower per-beneficiary costs for self-funded employers paying for employee health expenses directly.)

But there are disadvantages to employer-sponsored coverage as well. Because employers are not currently required to offer coverage, not all workers have access to it. Losing a job or deciding to start one's own business has in the past resulted in loss of coverage for some, as has retirement or a shift to part-time status.

Some of the disadvantages will go away in 2014, however, when major provisions of the Affordable Care Act go into effect (see details below).

RESPONSES TO PREMIUM INCREASES

Premiums have been increasing faster than inflation, workers' earnings and the gross domestic product. (See chart, "Percent Increase in Health Insurance Premiums vs. Other Indicators, 2001 – 2010.") Between 2000 and 2010, the average cost of health premiums increased by 104 percent for employee-only coverage and 114 per-



cent for family coverage,[20] while the Consumer Price Index increased 27 percent.[21]

As premiums have risen over the years, employers have tried different strategies to curb the growth in their health care costs. One way is to have employees pay more out of pocket for deductibles and co-payments. (See glossary for definitions.) This means less expense for insurers (and self-insured employers) and, theoretically at least, lower premiums.

For instance, workers in preferred provider organizations having a general annual deductible for single coverage saw their yearly deductible more than double from 2003 to 2010 – from $275 to $675.[22, 23]

Among their cost containment strategies, employers in 2010 shifted more of the cost of premiums to employees. Workers had been paying about 16 percent of the premium for single coverage since 2002, and between 26 and 28 percent of the family premium. Both figures jumped in 2010, to 19 percent of the premium for single coverage and 30 percent for family coverage.[24]

Employees could pay even more in the future. A 2010 study by PricewaterhouseCoopers found that among 700 employers surveyed, 42 percent of respondents said they intend to increase employee contributions in the future.[25]

The year 2011 could see a slackening in the pace of employer health costs. A survey of large employers by the Mercer company found that employers expect to hold the increased cost of their health benefits to 6.4 percent, primarily by making changes in plan design or by changing vendors. In contrast, the same employers said they saw a 6.9 percent increase in average per-employee costs in 2010, the largest increase since 2004.[26]

CONSUMER-DIRECTED PLANS

To help reduce costs, employers have also shown interest in a relatively new type of health plan. Frequently referred to as consumer-directed health plans (CDHPs), these plans combine higher deductibles with tax-preferred accounts that can be used for out-of-pocket health care expenses.

The plans encourage employees to be more cost conscious about their health care spending, since they feel as if they are spending their own money for expenses up to the deductible amount. For 2011, minimum deductibles of $1,200 for self-only coverage and $2,400

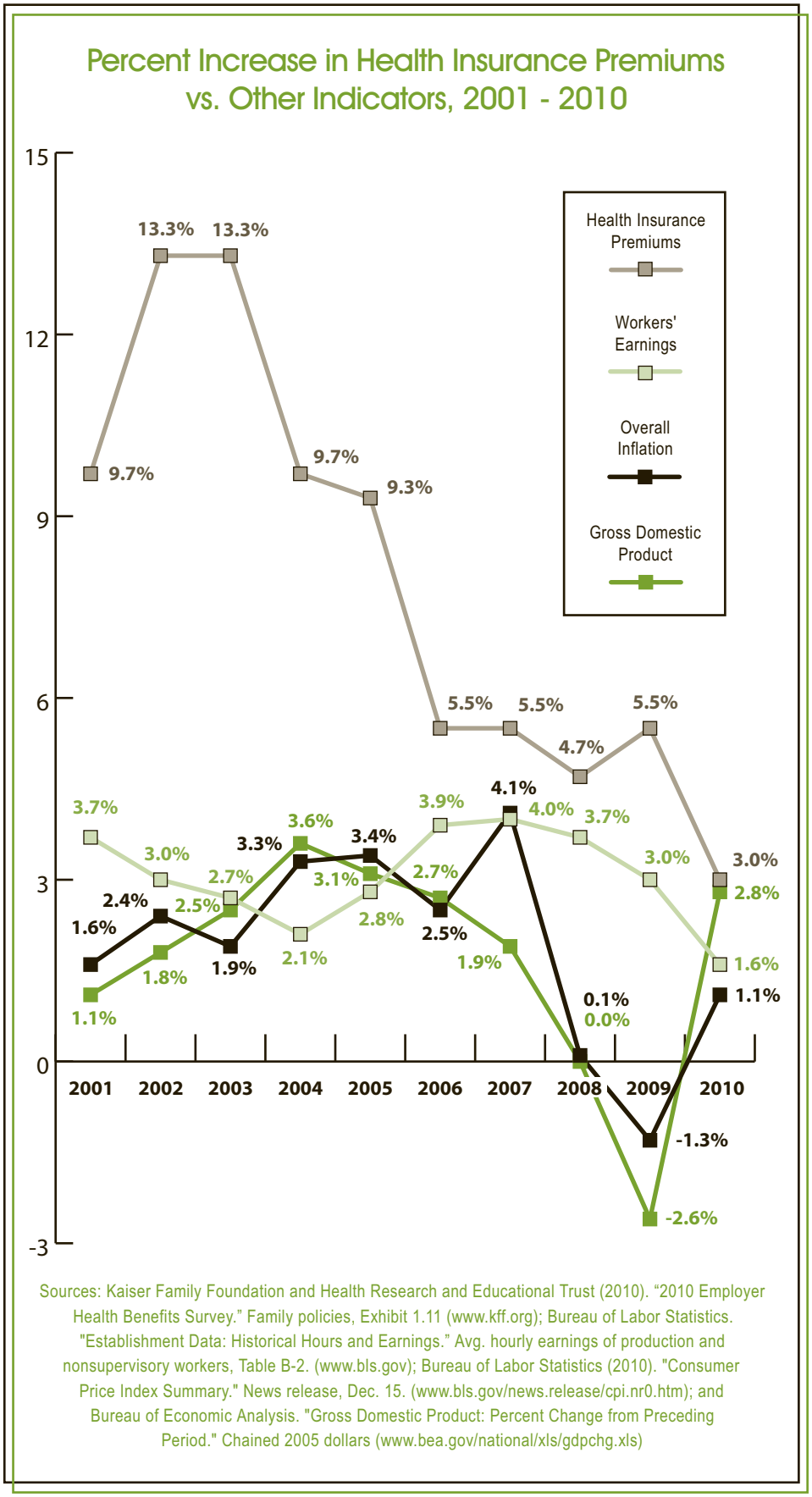
for family coverage are required for an individual to be eligible to make tax preferred contributions to their health savings account (HSA).[27]

Enrollment in consumer-directed plans is growing steadily. The Mercer report mentioned earlier found that in 2010, 11 percent of all covered employees were in consumer-directed health plans, up from 9 percent in 2009.[28]

One reason for this growth may be lower premiums. A report from the Employee Benefit Research Institute noted an average savings of 4.8 percent in premiums for CDHPs compared to other types of health plans, due in part to younger, healthier workers choosing CDHPs.[29]

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Patient Protection and Affordable Care Act (ACA) has major implications for employment-based health benefits. The law provides some immediate benefits, such as subsidies to help small employers provide health coverage and allowing dependents up to age 26 to stay on a worker's health plan. In later years, the law carries penalties, such as the requirement that employers with 50 or more workers must offer health coverage or pay a $2,000 fee per full-time employee (with the first 30 employees excluded).[30]



Sources: Kaiser Family Foundation and Health Research and Educational Trust (2010). "2010 Employer Health Benefits Survey." Family policies, Exhibit 1.11 (www.kff.org); Bureau of Labor Statistics. "Establishment Data: Historical Hours and Earnings." Avg. hourly earnings of production and nonsupervisory workers, Table B-2. (www.bls.gov); Bureau of Labor Statistics (2010). "Consumer Price Index Summary." News release, Dec. 15. (www.bls.gov/news.release/cpi.nr0.htm); and Bureau of Economic Analysis. "Gross Domestic Product: Percent Change from Preceding Period." Chained 2005 dollars (www.bea.gov/national/xls/gdpchg.xls)

Here is a timeline of provisions in the ACA as they may affect employment-based health plans.[31]

2010

- Temporary reinsurance program for retiree health benefits: Employers are able to apply for a subsidy to cover 80 percent of the cost of claims between $15,000 and $90,000 for retirees ages 55 and older who are not yet eligible for Medicare. $5 billion was set aside for use until Jan. 1, 2014, or when the funds are exhausted.
- Subsidies to employers: Employers with fewer than 25 employees and average annual earnings below $50,000 are eligible for a tax credit to cover part of their cost of providing health insurance. Between 2010 and 2013, a tax credit of up to 35 percent of the employer's costs is available for employers contributing at least 50 percent of the premium. Tax-exempt small businesses meeting these requirements are eligible now for tax credits of up to 25 percent of the employer's contribution. In 2014 and beyond, a 50 percent tax credit is available, but only for two years. Tax-exempt organizations can claim a 35 percent credit starting only in 2014.
- Ban on lifetime limits for covered expenses and restrictions on annual limits.
- Dependents up to age 26 are allowed to participate in their parents' plan.
- No refusing coverage to dependent children under age 19 because of pre-existing conditions.
- Cost-sharing (i.e. out-of-pocket dollars) is prohibited for certain preventive services.
- Emergency care outside a plan's network must be provided at in-network cost sharing levels.
- Internal/external appeal processes are to be established.
- Insured plans cannot discriminate in favor of highly compensated workers (similar requirements already apply to self-insured plans).
- OB/GYN or pediatrician can be designated as a primary care physician

2011

- Tax penalty on nonqualified HSA withdrawals doubled to 20 percent.
- Over-the-counter medicine is not eligible for FSA, HSA, or HRA reimbursement unless obtained with a prescription.

2012

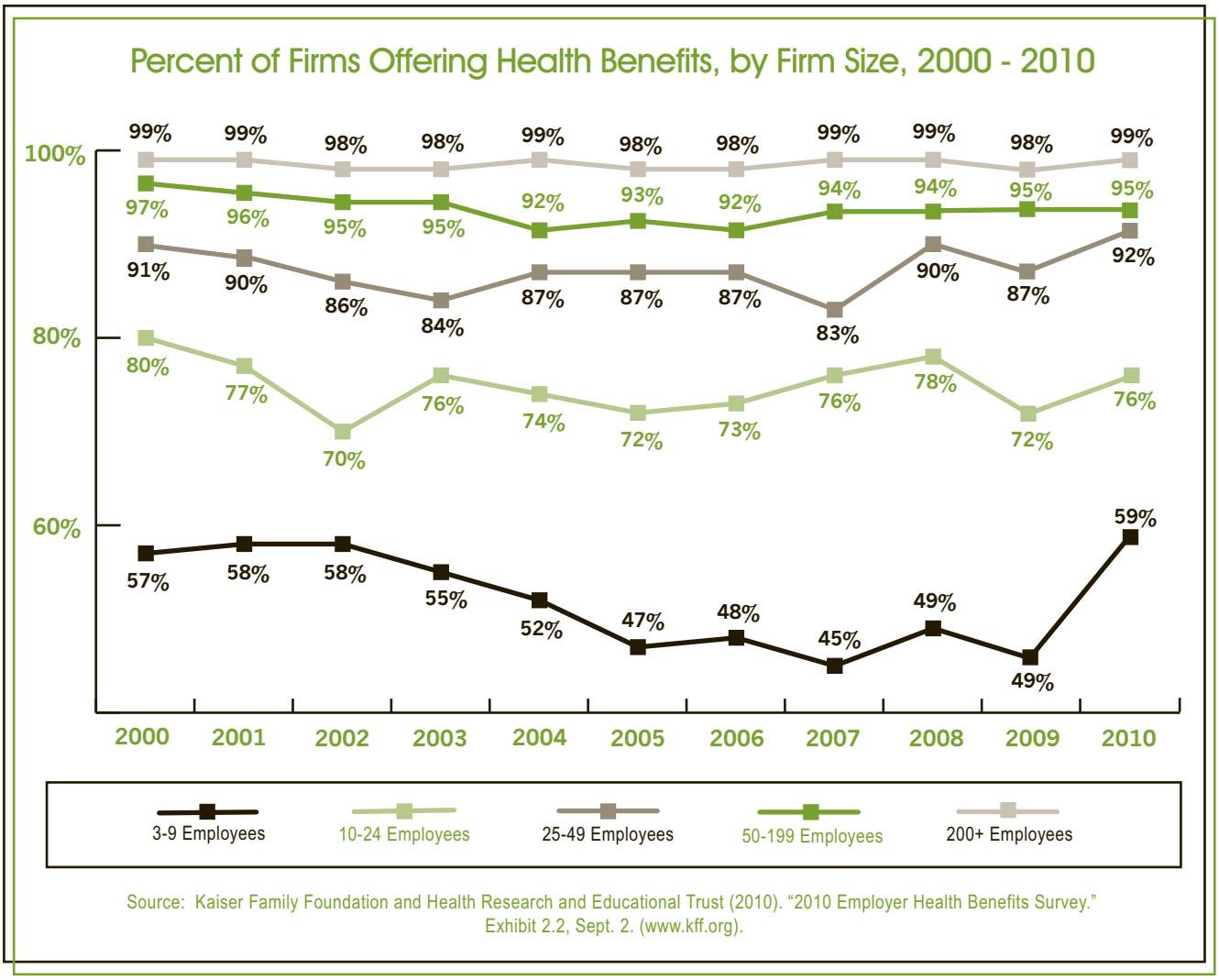
- Employers are required to report the value of health coverage on W-2 forms (covering the year 2011).
- Health plans are required to pay, in FY 2013, a comparative effectiveness/patient-centered outcomes fee of $1 multiplied by average number of covered lives in the plan. The fee goes up to $2 for plan years ending after Sept. 30, 2013
- Uniform benefit summary must be provided.

2013

- FSA contributions capped at $2,500.
- Federal subsidy to employers for Medicare-eligible retiree drug expenses becomes taxable.

2014

- Employers who do not provide qualifying health coverage are required to pay $2,000 per full-time worker (first 30 workers are excluded). Employers with 50 or fewer workers are excluded from penalty. Penalty applies only if one or more workers opt out of employer coverage and receive subsidized coverage through a health insurance exchange.
- Employers with fewer than 100 workers are eligible to provide health benefits through state-based health insurance exchanges. (See more on exchanges below.)
- Employers required to offer a "free choice voucher" to employees with incomes less than 400 percent of federal poverty level whose share of the premium exceeds 8 percent but is less than 9.8 percent of their income and who choose to enroll in a plan in the health insurance exchange. The voucher is equal to the employer portion of the premium.



Source: Kaiser Family Foundation and Health Research and Educational Trust (2010). "2010 Employer Health Benefits Survey." Exhibit 2.2, Sept. 2. (www.kff.org).

- Automatic enrollment required by employers with 200 or more workers.

2017

- States may allow employers with 100 or more workers to buy health benefits through health insurance exchanges.

2018

- Excise tax on high cost health plans. A 40 percent excise tax is imposed on plans with an aggregate value exceeding $10,200 for individual coverage or $27,500 for family coverage. The tax is applied to the value of the plan above those thresholds.[32]

As mentioned above, the ACA offers a tax credit for some small employers to offer health coverage or continue their existing coverage. The credit may already have helped. The portion of businesses with three to nine workers offering coverage increased from 46 percent in 2009 to 59 percent in 2010.[33] Increases were seen as well among firms with 10 to 24 workers, and 25 to 49 workers. (See chart, "Percent of Firms Offering Health Benefits, By Firm Size, 2000 – 2010.")

But researchers say the increase could also be due in part to small firms that didn't offer coverage going out of business during the recession, increasing the percentage of surviving firms offering the benefit.[34]

Analysts have wondered whether employers with more than 50 workers will choose to pay the $2,000 per employee penalty rather than offer coverage beginning in 2014. Since 96.5 percent of firms this size already offer coverage,[35] this provision in the law

has not been particularly controversial. Nonetheless, some firms could decide that paying the penalty is less burdensome than the cost of coverage.

Some people look to Massachusetts to see whether an employer mandate causes firms to drop coverage. In that state, a health insurance mandate went into effect in mid-2007, affecting both consumers and employers. Rather than receding, the number and percentage of people covered through employment in Massachusetts rose in 2007 and 2008, slipping back in 2009 perhaps because of the recession.[36]

For more details on provisions in the ACA affecting employers, see the Alliance for Health Reform issue brief, "Implementing Health Reform: Employer & Consumer Issues" at www.allhealth.org.

HEALTH INSURANCE EXCHANGES

Beginning in 2014, each state will have a health insurance exchange available where qualified individuals can buy coverage.[37] Each state will also have a small business exchange available, where firms with up to 100 employees can buy coverage for their workers, unless the state decides to allow only firms with up to 50 employees to take part (an option that states have). These will be called Small Business Health Option Programs (SHOPS). Businesses with more than 100 employees will be able to purchase coverage through the small business exchange beginning in 2017, at state option.

States can join together to create regional exchanges. They can combine the individual and small group exchanges. They can also create more than one exchange within a state, as long as each serves a defined geographic area.

All policies offered through exchanges will have a minimum benefit package. Given that, consumers will be able to choose from among four levels of policies. Within each level, states can determine the combination of benefits and consumer cost-sharing to be offered. [38]

Exchanges are intended to increase competition among private insurers, thereby perhaps lowering costs. By pooling together many purchasers, they also aim to give small businesses the buying power that larger businesses now enjoy.[39]

(For more information on exchanges, go to http://goo.gl/cUTp.)

TIPS FOR REPORTERS

- The Affordable Care Act and its provisions affecting employer-sponsored coverage are rich with story possibilities. For a good summary of the law by the Kaiser Family Foundation, including provisions affecting businesses, go to www.kff.org/healthreform/upload/8061.pdf
- For experts on employer-sponsored coverage and the reform law, sign up for the Alliance for Health Reform's Find-an-Expert Service for reporters – www.allhealth.org/reporter_enroll.asp
- Keep in contact with state business groups (Chamber of Commerce, National Federation of Independent Business), health consumer groups and other groups active in coverage issues.
- Remember that AARP has an interest in employment-based health benefits as well as in Medicare. State chapters can be helpful in providing reaction to private-sector or government health proposals.
- Don't overlook your state insurance department as a source of data, expert comment and story ideas
- Take an insurance agent to lunch. Ask how the agent expects his or her role to change after health insurance exchanges become active in all states by 2014. Also, get to know the leaders of your state's chapter of the National Association of Health Underwriters - www.nahu.org/about/chapters.cfm
- Build and update a data resource bank for your state with the number of insured/uninsured, sources of coverage, recent trends, etc. (Statehealthfacts.org, a service of the Kaiser Family Foundation, has a wealth of information for your state.)
- State officials have some key responsibilities

under the reform law, and some key decisions to make on how (and whether) to set up a health insurance exchange for your state. Keep in touch with the relevant officials.

- Keep an eye on the docket for the supreme court in your state for health issues that may result in important judicial opinions.

STORY IDEAS

- How many small businesses in your area are applying for the federal tax credits available now to help them pay for their workers' coverage?
- Are business in your area applying for the federal "reinsurance" subsidies available to help pay for retiree coverage?
- Many states are well into their planning for the health insurance exchanges that begin in 2014. What's happening in your state? If your state plans to "opt out" and allow the federal government to set up an exchange for your state's citizens, what is the federal government doing to get ready?
- Find local people who are employed but who do not have employment-based health benefits, and explain the reasons why they do not. Will their situation change after full phase-in of the ACA?
- Do the same with the so-called "underinsured," those who have skimpy coverage. Will their situation improve as a result of the health reform law? How popular are so-called "mini-med" plans in your area – plans with bare-bones benefits for a small monthly premium? Has any of these plans received a waiver from the federal Health and Human Services Dept. allowing them to be sold despite their relatively thin coverage?
- Be on the lookout for two key reports each year on trends in employer-sponsored coverage: the Kaiser/HRET Annual Employer Health Benefits Survey (www.kff.org/insurance/employer.cfm), usually released in September, and the annual report on health benefits from Mercer Consulting (www.mercer.com), usually released in November. Both give you a hook for stories about local trends.
- What are local businesses and business groups doing to control the cost of health coverage?
- What do local people who now have coverage through their job think of getting health coverage through an insurance exchange instead?
- What provisions in the Affordable Care Act do business groups in your area want to see repealed? Would they like to see such provisions gone entirely, or replaced with something else?
- Do some businesses in your area plan to drop coverage in response to the ACA?

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CHAPTER

INDIVIDUAL HEALTH COVERAGE

Originally written by Karen Pollitz, Georgetown University Health Policy Institute, and updated by Deborah Chollet and Allison Barrett, Mathematica Policy Research, and Bill Erwin, Alliance for Health Reform.

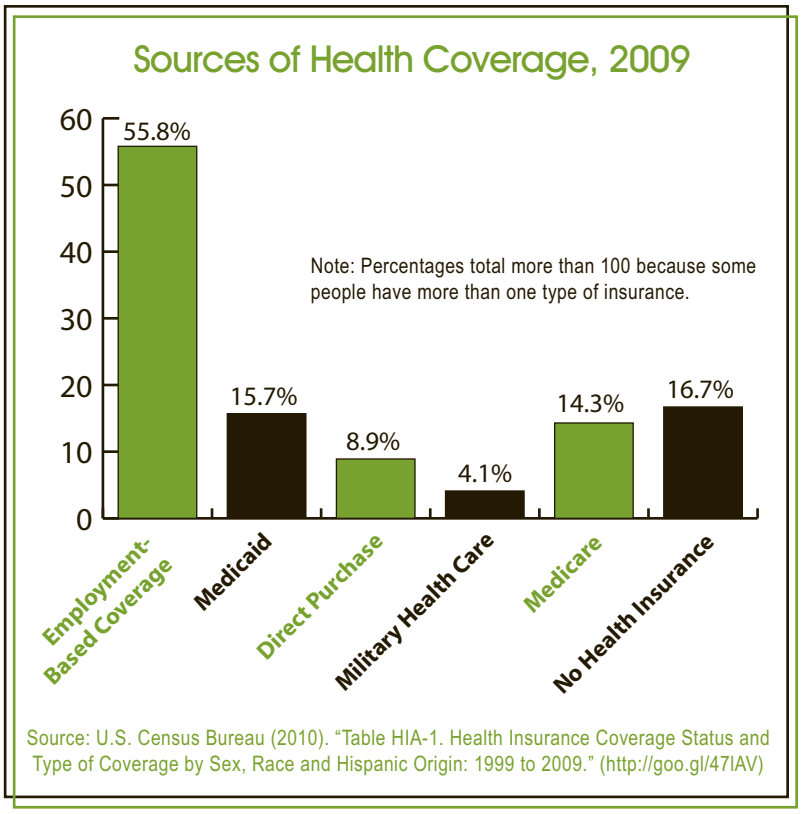
FAST FACTS

- 16.8 million people under age 65 were covered by an individual health insurance policy in 2009.[1]
- By 2019, this number is expected to grow to 24 million due to provisions in the federal health reform law, the Patient Protection and Affordable Care Act (or ACA, for short).[2]
- Currently, most individual policies are medically underwritten, meaning insurers can deny or restrict coverage, or charge higher premiums because of an applicant's medical history.[3] The ACA will substantially change the individual coverage market in the U.S., eventually ending medical underwriting and eliminating higher premiums charged because of a person's medical history.
- Today, individual policies typically cost less than group health plans, but they provide less coverage.[4] High deductibles are the norm and some key benefits such as mental health, prescription drugs, or maternity care may be limited or not covered at all. The ACA, when fully implemented in 2014, will change these practices.
- Also starting in 2014, the ACA will require nearly all Americans to have health insurance. Health insurance exchanges will help consumers compare prices and policies and obtain subsidies to buy coverage, if their income is less than four times the federal poverty level and they cannot get coverage from their employer or a public coverage plan, such as Medicaid.
- The ACA creates a temporary, federally subsidized high-risk insurance program in every state, but only individuals who have been uninsured for at least six months can enroll. Apart from these temporary pools, 34 states make coverage available to people who have trouble buying individual coverage because they have health problems.

See p. 62 for story ideas and p. 63 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=121

BACKGROUND

Because of the Patient Protection and Affordable Care Act of 2010 (ACA, for short), the world is changing for people who want to buy health insurance on their own in the individual market (or who have tried unsuccessfully to do so in the past). No longer can insurers refuse to cover children with pre-existing conditions. Anyone with a pre-existing condition can now buy coverage at more reasonable rates through a state-level high-risk pool, if they've been uninsured for at least six months.



Source: U.S. Census Bureau (2010). "Table HIA-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1999 to 2009." (http://goo.gl/47IAV)

5

In 2009, 27.2 million people, including 16.8 million people under age 65, bought health insurance in the individual market.[5,6] (See chart, "Sources of Health Coverage, 2009.") In general, people turn to the individual market for coverage when they don't qualify for job-based health benefits or public programs.

While only about 6 percent of all people under age 65 have individual health insurance in a given year,[7] this percentage will grow because of provisions in the ACA noted in the Fast Facts above and in the section on "Federal Reform of Individual Coverage" below.

People of all ages have individual coverage. According to America's Health Insurance Plans (AHIP), a trade association, 40 percent of single policies were held by people aged 45-64 in 2009; 37 percent were held by people between 25 and 44 years old; and 23 percent were held by people aged 24 and under.[8]

Currently, because insurers in most states can deny or restrict coverage to adults, or charge a higher premium because of an adult applicant's medical history (a practice called medical underwriting), people who buy individual health insurance tend to be in good health.[9]

Premiums for individual health insurance tend to be lower than for job-based health plans. In 2009, the average non-group policy for one person was 38 percent less expensive than the average employer-sponsored policy, according to AHIP. Family coverage was 53 percent less expensive when purchased on the non-group market.[10]

Non-group policies are cheaper in part because they generally offer less coverage than employer-sponsored or other group policies. One study of the individual market in 10 states found that individual policies paid 66 percent of medical costs for beneficiaries' covered services in 2007, compared with 80 percent in employer-based plans.[11]

Another study found that individual market insurance policies in California paid for just 55 percent of the expenses for covered services in 2006, compared to 83 percent for small group health plans.[12] Deductibles in individual policies were about three times as large as in employer-based plans.[13] (See glossary for the definition of "deductibles.") Individuals can put money into tax-free health savings accounts (HSAs) to help pay out-of-pocket expenses, if their policy qualifies as a "high deductible health plan" under federal law. (See the chapter on employer-sponsored coverage for more on HSAs.)

Premiums for individual coverage are increasing sharply, however. People who bought their own insurance reported in a June 2010 study by the Kaiser

Individual Market, Average Premiums by Age, 2009

	SINGLE		FAMILY		
	Number of Policies	Average Annual Premium	Number of Policies	Average Members per Family	Average Annual Premium
Under 18	139,652	$1,350	21,866	2.22	$2,573
18 -24	269,027	$1,429	13,112	2.26	$2,967
25 -29	265,472	$1,723	37,069	2.67	$3,756
30 -34	148,843	$2,104	65,409	3.13	$4,512
35 -39	127,972	$2,457	97,319	3.43	$5,148
40 -44	131,481	$2,888	120,383	3.50	$5,736
45 -49	156,646	$3,414	137,218	3.33	$6,404
50 -54	170,582	$4,127	123,219	2.95	$7,331
55 -59	185,791	$4,895	90,632	2.51	$8,414
60 -64	208,117	$5,755	56,071	2.21	$9,952
All Age Groups (non-elderly)	1,803,583	$2,985	762,298	3.03	$6,328

Source: America's Health Insurance Plans. (http://goo.gl/D5Uta)

Family Foundation that their insurers were asking for premium increases averaging 20 percent.[14]

Premiums vary considerably by age. The average annual premium for individually-purchased single coverage in 2009 was $1,350 for those under age 18 vs. $5,755 for those age 60 to 64.[15] (See text box, "Individual Market, Average Premiums by Age, 2009.")

Premiums also vary by state. In North Carolina, for instance, the average premium for an individually-purchased family policy was $5,120 in 2009, compared to $13,296 in New York State.[16] (See text box, "Individual Market, Average Annual Premiums in Selected States, 2009.")

REGULATION OF INDIVIDUAL HEALTH INSURANCE

Because states regulate individual insurance, consumer protections in this market currently depend largely on where one lives. Today, insurance companies dealing with adult applicants in most states can reject applicants outright, exclude coverage for certain conditions or charge higher premiums based on their health status.[17] (The ACA already prohibits the first two of these practices when applying for children's coverage, and in 2014, they will be outlawed for all applicants.[18])

Current federal law requires insurers in every state to renew individual coverage regardless of the policyholder's health status.[19] But in some states insurers can employ various rating and marketing practices to raise the price of coverage for policyholders who get sick. In just five states – Maine, Massachusetts, New Jersey, New York and Vermont – individuals are protected against all underwriting actions both when they first apply for coverage and when they renew.[20] (For the latest information on specific states, go to www.healthinsuranceinfo.net, a service of the Georgetown University Health Policy Institute.)

Regulations protecting consumers come with a price, however. For instance, "community rating" regulations limit the degree to which premiums can differ for different types of people. In its most stringent form, community rating requires that the old pay the same premium as the young for an equivalent policy, and the sick pay the same premium as the healthy. A 2008 study found that community rating raises premiums by 10 to 17 percent for individual policies in the non-group market, and 21 to 22 percent for family policies.[21] This will change in 2014 when provisions of the ACA affecting individual coverage go into effect, as discussed below.

Now, when applicants are denied individual coverage,

Individual Market, Average Annual Premiums in Selected States, 2009

State	Single	Family	Average Family Size
New York	$6,630	$13,296	2.84
Massachusetts	$5,143	$13,288	3.52
Rhode Island	$4,779	$11,107	3.26
Maine	$4,061	$7,260	2.92
Connecticut	$3,503	$8,477	3.09
New Hampshire	$3,427	$7,672	2.91
Montana	$3,305	$5,968	3
Nevada	$3,276	$6,119	2.89
Virginia	$3,229	$6,383	2.99
Georgia	$3,228	$7,408	3.38
Oklahoma	$3,220	$5,947	3.02
Texas	$3,208	$6,459	3
South Carolina	$3,204	$6,128	3.05
Florida	$3,191	$6,527	2.94
Tennessee	$3,150	$5,957	2.91
Minnesota	$2,978	$7,013	3.22
Arizona	$2,961	$5,292	3.09
Nebraska	$2,950	$5,979	3.24
California	$2,943	$6,567	2.96
Indiana	$2,930	$6,236	3.09
Pennsylvania	$2,873	$6,381	3.05
Illinois	$2,843	$6,317	3.04
Colorado	$2,777	$5,939	2.96
Kentucky	$2,740	$5,980	2.96
Missouri	$2,725	$5,657	2.97
Ohio	$2,724	$5,701	3.1
Kansas	$2,615	$5,529	3.1
North Carolina	$2,613	$5,120	3.03
Iowa	$2,606	$5,609	3.11

Source: America's Health Insurance Plans. (http://goo.gl/D5Uta)

charged higher premiums or offered fewer benefits because of health problems, they can turn to a state high-risk pool to buy coverage. The ACA requires that in temporary high-risk pools created by the legislation, applicants can't be charged more than a person without a pre-existing condition would pay in the individual market. In order to apply, a person must have been uninsured for at least six months and must be a U.S. citizen or legal immigrant.[22] (See "Federal Reform of Individual Coverage" below.)

CURRENT LACK OF SUBSIDIES

Many individuals with directly purchased health insurance have low incomes. In 2009, 5.6 million people with household incomes of less than $25,000 had non-group private coverage.[23]

Individual coverage is not subsidized through the tax code as job-based coverage is. Individuals and families are responsible for the entire premium, without employer contributions or extensive income tax breaks. The federal government provides a health coverage tax credit to subsidize individual coverage for a few thousand eligible early retirees and certain workers who lose their jobs because of foreign competition.[24]

Otherwise, nine states – Arizona, Indiana, Maine, Massachusetts, New Mexico, New York, Tennessee Vermont and Washington State – subsidize premiums to help low-income residents buy individual health insurance.[25] (Beginning in 2014, all states will offer subsidies, as described in the next section.)

Because the ACA allows states to extend Medicaid coverage to all residents under 133 percent of the poverty line (and requires all states to do so by 2014), these states may instead choose to offer Medicaid to many individuals in those subsidy programs.

FEDERAL REFORM OF INDIVIDUAL COVERAGE

The ACA establishes many new protections for consumers buying individual coverage. The first of these became effective in 2010 and on Jan. 1, 2011; others take effect in 2014. Ultimately, the ACA will fundamentally restructure the individual market in every state.

CHANGES EFFECTIVE IN 2010-2011

A temporary federally-approved high-risk pool is now open in every state for individuals who are denied coverage because of a health problem and have been uninsured at least six months. Enrollees in these high-risk programs pay the same premiums that healthy people would pay on the individual market and out-of-pocket costs are limited. Premiums are not scaled to income.[26]

In September 2010, individuals gained basic protections in both current and new policies:[27]

- Insurers cannot cancel coverage retroactively when the policyholder becomes ill (a practice called "rescission"), except for nonpayment of premiums or fraud.
- Insurers may not place lifetime limits on amounts paid for covered services, nor place unreasonable annual limits on these amounts.
- Insurers must cover pre-existing conditions for dependents under age 19.
- Dependent children may remain on a family policy until they turn 26.

In January 2011, additional protections took effect:

- Insurers can spend no more than 20 percent of individual premiums on administrative costs and profit, refunding any excess to policyholders. (Amounts spent on actual care are termed "medical loss" and the percentage of premiums spent on care is the "medical loss ratio.")
- Individual policies issued subsequent to the ACA's enactment (March 23, 2010) must cover a standard set of preventive services without cost sharing.

CHANGES EFFECTIVE IN 2014

In 2014, the individual market will undergo major change:

- Insurers must accept all applicants and cover pre-existing conditions for new and current policyholders. They can vary premiums only by the individual's age, geographic location, and tobacco use, and for single versus family coverage.[28]
- To prevent healthy people from waiting until they need health care to buy insurance, which would increase premiums for everyone, nearly all U.S. residents will be required to maintain coverage. (This is the widely publicized and debated "individual mandate" in the law.) Exceptions will be given for financial hardship and religious objections, and to American Indians, people who have been uninsured for less than three months, those for whom the lowest cost health plan exceeds 8 percent of income, and those with an income below the tax filing threshold.[29]
- States will create "exchanges" where individual consumers can compare premiums for policies of similar value and buy coverage.
- Individuals who buy coverage through an exchange can qualify for a premium subsidy if their income is below four times the federal poverty line and they are ineligible for an employer plan or public program.[30] These individuals will spend no more than 10 percent of income on premiums. All new policies must cover "essential benefits" (including maternity and newborn care, mental health and substance abuse services, and prescription drugs), and annual out-of-pocket costs will be capped.[31]

LIKELY POLICY DEBATES

INDIVIDUAL MANDATE

The ACA's requirement that individuals maintain health insurance coverage is an essential component of individual market reform. As of 2014, insurers must accept all applicants and cannot use medical underwriting, waiting periods for pre-existing conditions or coverage exclusions.

If not required to buy health insurance, say those who support the individual mandate, individuals will be very tempted to buy coverage in this market only when they are sick. If this happens, premiums will be higher for everyone, making it harder for individuals and families to afford coverage and more costly for government to subsidize premiums. Critics of the individual mandate worry that it will establish a precedent for social policy more generally.

Even though health reform is now law, the individual mandate remains controversial. Federal judges in Virginia and Florida have ruled that the individual mandate is unconstitutional. Three other district court judges, in Virginia, Michigan, and the District of Columbia, ruled that the mandate meets constitutional requirements. Most analysts agree that the U.S. Supreme Court will eventually settle the matter, probably taking up a case challenging the law in 2012.[32]

IMPACT OF REFORM ON INDIVIDUAL PREMIUMS

The ACA will change the way insurers set individual premiums. By 2014, premiums will no longer reflect individual health status, and the oldest individuals will pay no more than three times what the youngest pay for the same policy.

In most states, where insurers are allowed to charge a higher premium for those in poorer health and greater variation in premiums based on age are currently allowed, premiums for young and healthy individuals might increase in 2014, if their income is too high to qualify for the premium subsidy. Other requirements – that insurers accept all applicants, establish reasonable annual limits on coverage, and eliminate lifetime limits, preexisting-condition waiting periods, and benefit exclusions – are likely to further increase premiums for the youngest and healthiest individuals.

Advocates of these reforms (when taken together with income-scaled premium subsidies) see them as essential components of an individual insurance market that is accessible, affordable, and fair over the course of individuals' lifetimes. Critics are concerned that these reforms create a market that relies too heavily on government to make it work.

TIPS FOR REPORTERS

- Keep in mind differences between individual and group health coverage. If you haven't reviewed the employer-sponsored coverage chapter of this sourcebook, you will find that useful.
- Expand time horizons. Snapshots reveal differences in health insurance products and prices at a point in time, but this can change. Are the low premiums offered for some policies stable, or do they increase over time? Do covered benefits and deductibles change?
- You'll find state-by-state information on individual health insurance regulations at www.healthinsuranceinfo.net, a service of the Georgetown University Health Policy Center.
- Personal stories of people who have had problems with their health insurance will help you understand the motivation for the ACA's individual market reforms, and why many people would be upset if the movement to repeal the ACA were to succeed. Try the Families USA Consumer Story Bank (call 202-628-3030, or e-mail storybank@familiesusa.org). The Alliance for Health Reform's Find-an-Expert service also can help reporters find such individuals (www.allhealth.org/reporter_enroll.asp or 202-789-2300.)

STORY IDEAS

- New high-risk pool plans– How many people in your state have signed up for the high-risk pool created by the Accountable Care Act? Trying using Craigslist, Facebook, Twitter or other social networking sites to find people to interview. Are state officials encouraging enrollments, or ignoring the pool as a protest against the ACA? If they're encouraging enrollments, are they satisfied with the pace of sign-ups?
- Individual mandate – What do people in your area think of the individual mandate in the ACA? Do they get the connection between requiring almost all to have coverage and having coverage available at affordable rates to those with pre-existing health conditions?
- Guaranteed issue for children with pre-existing conditions – How are insurers in your area reacting to the provision in the ACA that prevents them from using a pre-existing condition as a reason to refuse coverage to children? Are they using this provision as a rationale for raising rates? What difference is the provision making for children in your area who were previously not eligible for individual coverage because of a pre-existing condition?
- Self-employed workers and early retirees –What

is the experience of self-employed workers and early retirees who rely on individual health insurance? How does medical underwriting work? Which benefits are covered, and which are excluded? What does the coverage cost when first purchased? Does this change over time, especially when they get sick or age into a higher rate class?

- Renewal practices – What happens now when individuals renew their policies? Do insurers in your market use "durational rating," so that the same policy costs more to renew than to purchase initially? Do policyholders try to moderate premium increases by increasing deductibles or dropping important benefits?
- Explore medical underwriting practices – Ask insurers/agents about conditions that are currently "uninsurable." Are policies routinely offered to applicants who are pregnant? Cancer survivors? Depressed? 20 pounds overweight?
- Explore coverage adequacy – How well do different policies pay for medical bills of policyholders who become sick, injured, or pregnant? What do providers do when a patient's insurance doesn't cover a needed service?
- Regulatory capacity – Who is your state insurance commissioner? How many staff work for her/him to regulate health insurance? Does the insurance commissioner review and question insurers about proposed premiums or premium increases? Does s/he approve rates, or can insurers charge premiums without approval?

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CHAPTER

CHILDREN'S HEALTH COVERAGE

Originally written by Bruce Lesley, First Focus, and updated by Bruce Lesley and Lisa Shapiro, First Focus, and by Bill Erwin, Alliance for Health Reform.

FAST FACTS

- More than half of children (55.8 percent) had health insurance coverage through their parent's employer in 2009.[1] An estimated 7.5 million children in the U.S. were uninsured for all of 2009, according to the Census Bureau – 10 percent of the nation's children.[2]
- Nearly 5 million children are eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP) but are not enrolled.[3]
- Uninsured rates for children vary dramatically by state, from a low of 2.9 percent in Massachusetts to a high of 17.9 percent in Florida in 2009.[4] Likewise, participation rates in Medicaid and CHIP vary by state – from a low of 55.4 percent of eligible children in Nevada in 2008 to 95.4 percent in the District of Columbia.[5] In 2008, almost four out of every 10 children eligible for Medicaid and CHIP but unenrolled lived in just three states – California, Texas and Florida.[6]
- Hispanic children are almost two and a half times as likely to be uninsured as non-Hispanic white children – 16.8 percent vs. 7 percent in 2009. Black children (11.5 percent) and Asian children (10 percent) were also more likely to be uninsured than whites.[7]
- The Affordable Care Act of 2010 affects children's coverage in a number of ways. Beginning in 2014, most children (like most adults) must have health coverage, either public or private.
- Because of the reform law, private insurers must now provide coverage for children with pre-existing conditions. Starting in 2014, the reform law provides refundable and advanceable tax credits to families with incomes between 133 and 400 percent of the federal poverty level to help them buy insurance through new exchanges.
- Dental caries, the disease causing cavities, is the most prevalent chronic condition among children. Yet, nearly three times as many children lack dental coverage compared to children without medical coverage.[9]

See p. 72 for story ideas and p. 73 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=122

BACKGROUND

Despite all the pain it caused, the recent recession was associated with one positive outcome – more children now have health coverage than before the recession hit. Between 2007 and 2009, 1.3 million children gained coverage and the number of uninsured children shrank by more than 600,000.[9]

The recession stimulated congressional action that increased coverage among children. The economic stimulus bill signed in February 2009 gave states financial incentives to sign up children for Medicaid and the Children's Health Insurance Program (CHIP). In addition, the CHIP reauthorization bill of 2009 offered bonuses to states for successfully boosting Medicaid enrollment of children using proven tools. Dozens of states did use these tools, such as simplifying enrollment and eliminating in-person interviews.[10, 11]

The net result: 4.4 million children were added to the rolls of Medicaid and CHIP between 2007 and 2009, more than making up for the 2.4 million who lost coverage through a parent's employer.[12]

But 7.5 million children remained uninsured in 2009.[13] About 5 million of these are eligible for Medicaid and CHIP but weren't enrolled.[14]

Not all states welcome federal efforts to cover more children. As states struggle to balance their budgets, some are looking for ways to delete children from Medicaid or CHIP. Even so, the number of children with coverage will keep growing. The Patient Protection and Affordable Care Act of 2010 (or ACA, for short) removes barriers to coverage for children with pre-existing conditions. The law expands Medicaid to cover more children. And as of 2014, almost everyone in the U.S., including children, will have to have coverage, or else pay a penalty.[15] (See details below.)

HOW DO CHILDREN GET HEALTH COVERAGE?

EMPLOYER-SPONSORED COVERAGE

The majority of children, an estimated 55.8 percent, had coverage through their parent's job-based insurance in 2009.[16] But this share has declined in recent years. In 2000, by contrast, 65.9 percent had job-based coverage. (See chart, "How Children Get Health Coverage, 2000 vs. 2009.")

The recession and the resulting rise in unemployment contributed to this trend. A 2010 study found that for every 1,000 jobs lost, 311 privately insured children lose coverage.[17]

Also, a shrinking number of eligible workers are taking up the coverage their employers offer, among both large and small employers.[18] Employees are expected to pay more for premiums and for out-of-pocket expenses than in years past.[19, 20] Employer-sponsored coverage is now less affordable for families with incomes at 300 percent of the federal poverty level (FPL) than it was for families at 200 percent of FPL in 1999.[21] (See text box, "2011 Federal Poverty Guidelines").

MEDICAID AND CHIP

While employer-sponsored coverage of children has dropped over time, Medicaid and CHIP coverage has increased, compensating for the employment-based decline. In 2009, an estimated 25.3 million children had Medicaid or CHIP for the full year, compared to 15 million in 2000.[22]

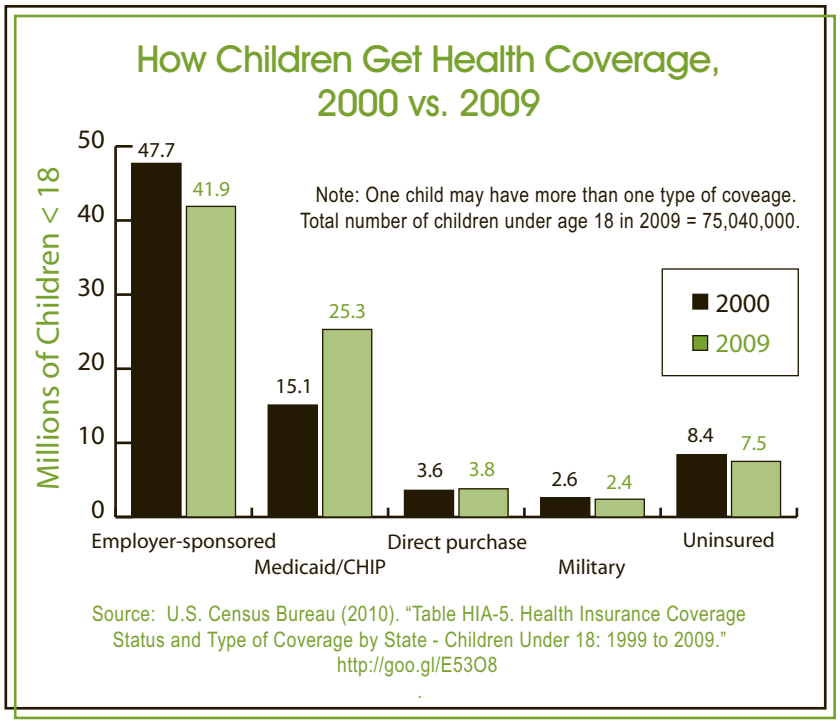
Together Medicaid and CHIP cover one in three children (33.8 percent).[23] (CHIP was previously called SCHIP—State Children's Health Insurance Program—until passage of the program's reauthorization in early 2009.)

Children represented 53 percent of all Medicaid enrollees in 2009.[24] But children constitute only a fraction of total program costs, since they are relatively inexpensive to cover compared to other Medicaid enrollees.

Federal law currently requires state Medicaid programs to cover children age 6 to 18 living in families with incomes below 100 percent of the federal poverty level or less, and children under age 6 living below 133 percent of the FPL.[25] In contrast, CHIP eligibility in most states goes up to at least 200 percent of FPL. (See text box, "2011 Federal Poverty Guidelines.") CHIP was designed to expand upon and complement Medicaid by providing health coverage for uninsured

children whose families earn too much to qualify for Medicaid, but who cannot afford private coverage.

Since the passage of CHIP, the percentage of low-income children in the U.S. with health coverage has increased – from 76.2 percent in 1997[26] to 85 percent in 2009.[27] More than 5 million children were enrolled in CHIP as of Dec. 2009.[28]



Unlike Medicaid, which is an entitlement program, CHIP is funded as a capped block grant to states. Under CHIP, each state is given a certain amount of money per year, determined by a formula established by Congress at the program's creation and modified several times since. To give states incentives to cover an expanded population of low-income children, the federal government provides states with an "enhanced" matching rate in comparison to Medicaid. For every dollar states spend on CHIP, they get more federal money than they do for every dollar they spend for Medicaid.

For CHIP, the federal government is paying from 65 percent to 82 percent of total program costs in FY 2011, depending on the state, in contrast to a 50 to 75 percent matching rate for Medicaid.[29] For FY 2010, states spent $3.4 billion on CHIP, while the federal government spent $8 billion. For FY 2012, states are expected to spend $4 billion vs. $9.3 billion for the federal government.[30]

The Medicaid matching rate (also known as Federal Medical Assistance Percentage) temporarily increased by 6.2 percentage points for each state under the economic stimulus legislation passed by Congress in early 2009.[31] The Medicaid increase is scaled back for some states for 2011. States with high unemployment continue to get the 6.2 percent bonus from Jan. through June. The temporary bonus payments then end.[32]

(For FY 2011 state by state matching rates for Medicaid and CHIP, not counting the changes contained in the stimulus bill, go to http://goo.gl/w6DXc.)

CHIP REAUTHORIZATION

Congress initially authorized CHIP for a 10-year period that expired at the end of September 2007. Congress and the Bush Administration deadlocked on the shape of CHIP for the future, and compromised by extending the program through March 2009. Ultimately, CHIP was reauthorized and enlarged early in 2009.[33] The bill, signed by President Obama on Feb. 4, 2009, increased CHIP funding by about $32 billion through 2013 to cover an additional 4 million children.[34] Conceivably, this expansion could cut the number of uninsured children in half.

CHILDREN AND NATIONAL HEALTH REFORM

Immediately after the passage of CHIP reauthorization, Congress began a year-long debate on comprehensive health reform legislation. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

This sweeping legislation included key provisions related to children's health coverage. Most notably, the legislation preserves and extends CHIP through Sept. 30, 2019 with full funding for the program extended through fiscal year 2015.

Other provisions in the ACA to improve access, coverage, quality and outcomes for children include:[35]

- **Mandated coverage.** Children (like adults) must have health coverage, either public or private, beginning in 2014, unless they fall into one of the exceptions provided by the law (e.g., religious objection, financial hardship).
- **Elimination of pre-existing condition exclusions.** Private insurers must offer coverage for children with pre-existing conditions. This means both providing coverage for pre-existing conditions for currently insured children and not excluding children with pre-existing conditions from future coverage. This requirement became effective with the insurance plan year beginning after Sept. 23, 2010 (meaning Jan. 1, 2011 for most people).
- **Continued support for CHIP.** The reform law maintains the Children's Health Insurance Program (CHIP) through 2019. In 2015, states will receive a 23 percentage point increase in the CHIP match rate, up to 100 percent of costs. Current match rates range from 65 to 85 percent.
- **Simplified enrollment measures.** The ACA requires streamlined enrollment under Medicaid, CHIP and new state-level insurance exchanges.
- **Extended dependent coverage.** The law allows dependent children to stay on their parents' health plan until they reach age 26. This also became effective for most people on January 1, 2011.
- **More affordability for low-income families in the new exchanges.** Starting in 2014, the law provides refundable and advanceable tax credits to families with incomes between 133 and 400 percent of the federal poverty level to help them buy insurance through new exchanges.
- **Elimination of lifetime limits.** Insurers may no longer place lifetime limits on the dollar value of coverage. Beginning in 2014, insurers may no longer impose annual limits on coverage.

2011 Federal Poverty Guidelines

Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270
For each additional person, add	3,820	4,780	4,390

Source: Federal Register, Vol. 76, No. 13, January 20, 2011, pp 3637-3638 http://aspe.hhs.gov/poverty/11poverty.shtml

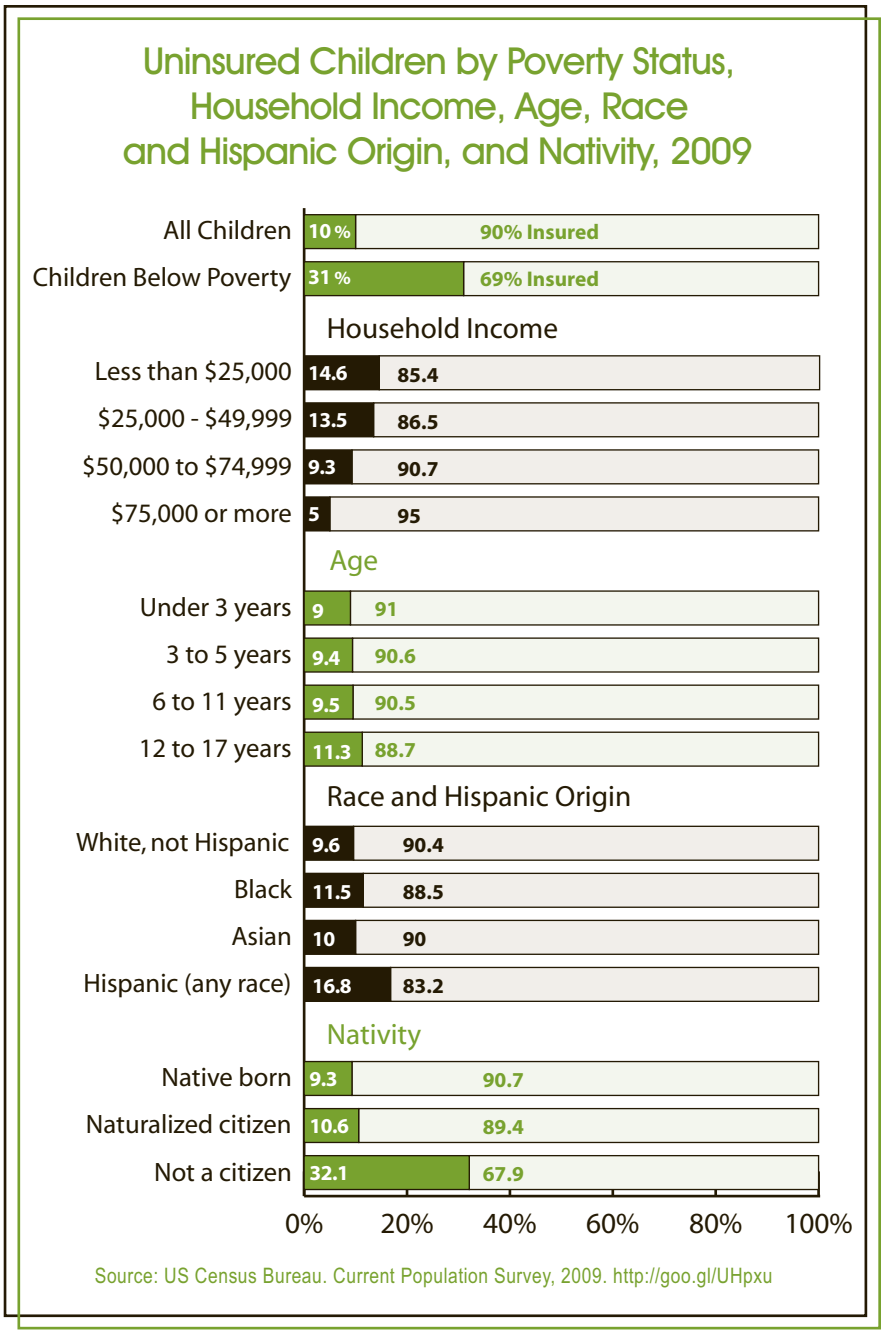
- **Oral health.** The law creates an oral health prevention campaign, dental carries disease management, school-based dental sealant programs and cooperative agreements to improve infrastructure and surveillance systems.
- **Coverage of preventive health services.** The law requires insurers to cover services, without out-of-pocket cost sharing, that have received an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), extending coverage for a broader range of preventive health services. (To see these recommended services, go to http://goo.gl/5YIkg.)
- **Child-only coverage option in the new exchanges.** The ACA allows families to purchase child-only insurance packages in the exchanges, to allow access to coverage for children being cared for by grandparents, children with parents whose employers do not offer dependent coverage, and children in mixed immigrant-status households.
- **Childhood Obesity Demonstration Project.** Authorized by Congress in the 2009 CHIP reauthorization, this project received $25 million through the ACA for a demonstration project to reduce childhood obesity.

WHICH CHILDREN ARE STILL UNINSURED?

Despite all the enrollment efforts and incentives mentioned earlier, 7.5 million children remained uninsured for all of 2009 – 10 percent of all children.[36] The uninsurance rate was highest for children who aren't U.S. citizens – more than 30 percent without coverage. Hispanic children were much more likely to lack coverage than non-Hispanic children.

Children in households with an income of less than $25,000 were more likely to be uninsured than children in households with greater income. Children ages 12 to 17 had a higher uninsurance rate than younger children. The South had a higher incidence of uninsured children than other regions.[37] (See chart, "Uninsured Children by Poverty Status, Household Income, Age, Race and Hispanic Origin, and Nativity, 2009.")

Participation rates of eligible children in Medicaid and CHIP vary tremendously by state, from a low of 55.4 percent in Nevada to a high of 95.4 percent in the District of Columbia. Almost four of every 10 children eligible for these programs but not enrolled lived in just three states – California, Texas and Florida.[38]



LIKELY POLICY DEBATES

CHILDREN AND NATIONAL HEALTH REFORM

Now that the ACA has been signed into law, efforts are underway to implement the provisions of the health reform legislation. The Department of Health and Human Services has already developed guidance implementing provisions that eliminate pre-existing condition exclusions for children and extending dependent coverage up to age 26.

Other key regulatory issues for children that are expected to be addressed in guidance in the coming weeks and months include: functionality issues related to exchange coverage, including how families will be treated with respect to eligibility for subsidies and transitions between public coverage and the exchanges; definitional issues related to pediatric benefits offered in the exchanges; and issues related to the elimination of cost-sharing for preventive care services.

Each of these issues is likely to draw competing opinions – from children's advocates, providers and state budgeteers. Also, threatened congressional action to withhold funding for ACA implementation, if successful, could have implications for children's coverage.

STATE BUDGET WOES AND HEALTH CARE FUNDING

As noted, additional support for Medicaid was included in the economic stimulus bill passed by Congress and signed by President Obama in early 2009. The American Recovery and Reinvestment Act temporarily increased each state's Medicaid matching rate through Dec. 31, 2010. Scaled back increases continue through June 2011, thanks to a separate law passed in mid-2010.[39]

After the temporary boost in funds runs out, states will be hard pressed to find funding to maintain eligibility levels and enrollments for children in Medicaid and CHIP. And they are constrained by "maintenance of effort" sections of the ACA that require states to maintain their current eligibility standards through 2019. States also are barred from imposing new paperwork or other barriers that would make it harder for people to enroll in Medicaid or CHIP. (See the Medicaid chapter for more information.)

TIPS FOR REPORTERS

- There is a unique children's health angle in virtually every health care policy discussion, whether about emergency medicine, benefits, privacy, quality, comparative effectiveness, tax credits, or organ transplants. As issues arise during health care discussions, consider how children's health issues are different from adult issues. Is there even a separate and distinct angle related to infant or adolescent health?
- For an excellent overview of CHIP and Medicaid, including the history of both programs and how they differ, see the first report from the new Medicaid and CHIP Payment and Access Commission (March 2011) at http://goo.gl/FnhVA
- Parents of young children have insights into children's health needs that often amaze, and impress, child health professionals. Talk with parents at places where they gather, such as day care centers, library story sessions or play groups.
- Some of the most powerful arguments for national health reform involve children with very expensive health conditions, and the devastating side effects this can have on their families and their finances. Get to know such families, and find out their views about changes still needed in the health care system.
- Hispanic children are much more likely to be uninsured than children of other ethnicities. Why is this true? You will find many interrelated causes. What do Hispanic parents and advocates recommend as solutions?

STORY IDEAS

- National health reform legislation is expected to improve health care access, coverage, and affordability, especially for low-income Americans and those who are currently uninsured. As ACA is implemented, how does coverage that is offered through the new exchanges stack up against existing coverage options for low-income children? For example, CHIP provides comprehensive benefits for children and limits out of pocket costs to 5 percent of a family's income. Under health reform, will families have the option to retain this coverage? Will the exchanges offer families coverage that provides comparable benefits and cost-sharing?
- In light of the federal government extending additional Medicaid dollars through June 2011 as part of state fiscal relief, what difference is this making directly to children's coverage in Medicaid and indirectly in CHIP? What will the end of this funding mean for children's coverage?
- Two-thirds of the uninsured children in the country are eligible for but not enrolled in either Medicaid or CHIP. What is your state doing with respect to outreach and enrollment of these children?
- How does your state use health information technology to improve the enrollment of eligible but unenrolled children? Do they use mechanisms

such as Express Lane Eligibility and SingleStop, which allow for sharing of data across programs to reduce bureaucracy and streamline enrollment?

- Dental caries (tooth decay) is the most prevalent, but also the most preventable chronic condition among children. What is your state or community doing to address this problem?

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CHAPTER 7

MEDICARE

Originally written by Gail Wilensky, Ph.D., Project HOPE, and updated by Marilyn Moon, American Institutes for Research, and by Deanna Okrent, Alliance for Health Reform.

FAST FACTS

- Medicare is a federal program that covered 46.6 million people in 2010 – most aged 65 or older. As of December 2009, the program also covered over 8.3 million people between the ages of 18 and 64 who met Medicare's definition of disability.[1]
- 4 million people who reached the "doughnut hole" in Medicare prescription drug coverage received a rebate from the federal government of $250 in 2010.
- The first of the boomer generation are reaching age 65 – the full Medicare eligibility age for non-disabled people – in 2011. By 2030, when the youngest boomer turns 65, there are expected to be 78 million people on Medicare.[2]
- Annual expenditures for Medicare were $519 billion in 2010 and are expected to rise to $929 billion in 2020.[3]
- The American Recovery and Reinvestment Act of 2009 included Medicare incentive payments to encourage physicians and hospitals to "meaningfully use" electronic health records. The incentives phase out over six years, followed by penalties for non-adopters.[4]
- The Patient Protection and Affordable Care Act (popularly known as the ACA) will result in a number of changes to the Medicare program. These changes will expand some benefits modestly and will achieve cost savings that will help to fund reforms for younger families.
- The net effects of the reform legislation are estimated to reduce Medicare spending by $575 billion between 2010 and 2019.[5] Financial assets of the Hospital Insurance Trust Fund that pays for Part A of Medicare are projected to be exhausted by 2029, an extension of 12 years as a result of the ACA.[6]

See p. 82 for story ideas and also for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=123

BACKGROUND

In March 2010 the Patient Protection and Affordable Care Act or ACA was signed into law. There was much concern by Medicare beneficiaries that the law would tamper with their benefits and eliminate essential elements of the program. Though some beneficiaries enrolled in private Medicare plans (known as "Medicare Advantage" plans) may see some supplemental benefits reduced, the vast majority will retain all benefits they previously held. And, all beneficiaries will receive some new or enhanced benefits.

Medicare was enacted in 1965 as a federal program that helps pay medical bills for people age 65 and older. At age 65, a person automatically becomes eligible for Medicare if he or she is a U.S. citizen or a legal resident (green card holder), and has lived in the U.S. for at least five years in a row.[7] In 2010, Medicare covered 46.6 million people – most aged 65 or older.

Medicare has been expanded since 1965 in terms of services and populations covered. The most important of these expansions were the decision to cover people with disabilities in 1972 and the coverage of outpatient prescription drugs enacted in 2003. Some 8.3 million people are on Medicare as disability beneficiaries. Eligibility for people with disabilities includes those who qualify for cash benefits under Social Security Disability Insurance (SSDI) after a two-year waiting period.[8] Special rules apply for those with end-stage renal disease (ESRD) or ALS, also known as Lou Gehrig's disease.

As with Social Security, eligibility for Medicare does not depend on income. Also like Social Security, much of Medicare is funded on a "pay-as-you-go basis," which means it depends primarily on today's working population to fund the expenses of today's beneficiaries. (See below for more on ratio of working population to beneficiaries.)

TRADITIONAL MEDICARE

Part A, known as the **Hospital Insurance** (or HI) program, covers inpatient hospital care, skilled nursing care for up to 100 days after a hospitalization, home health and hospice care. It is funded by a portion of the wage tax – 2.9 percent, with employers and employees each paying 1.45 percent. Beneficiaries pay a deductible ($1,132 for each "spell of illness" in 2011) and substantial copayments for extended inpatient hospital or skilled nursing facility stays.[9] (See the Glossary for definitions of deductibles and copayments.) If they or their spouse have worked in the U.S. for 10 years or more (40 quarters of Medicare-covered employment), beneficiaries pay no Part A premium.

Part B, known as **Supplementary Medical Insurance** (or SMI), covers physician services, outpatient care and home health care after 100 visits. It is funded partly by premiums, which account for 25 percent of the Part B revenue.[10] The rest comes from federal general revenue. The standard monthly premium is officially $115.40 in 2011.[11] For a majority of beneficiaries, however, the premium remains at the $96.40 level from 2008 because of a provision in law that freezes the increase when there is no cost of living increase in Social Security benefits. Some beneficiaries with higher incomes pay higher, income-related premiums; some with low incomes and assets pay no premiums. Most faced a Part B deductible of $162 in 2011. [12]

PRESCRIPTION DRUG BENEFIT

Part D is the Medicare outpatient prescription drug benefit which took effect in 2006. The benefit is provided by free-standing private drug plans. It is funded by general federal revenue (82 percent), contributions from the states for dual eligibles (7 percent), and premium payments from beneficiaries (10 percent). Beginning in 2011, higher-income beneficiaries will pay a larger share of the cost of standard drug coverage and receive a smaller premium subsidy.[13] Each plan sets its own premium; the national average in 2010 was $38.94 per month.[14] The maximum deductible allowed was $310.

MEDICARE ADVANTAGE

Also known as **Part C**, Medicare Advantage (or MA) is a plan which includes at least the benefits associated with traditional Medicare but replaces the benefits from parts A, B and in most cases D. In May 2010, 11.6 million Medicare beneficiaries were enrolled in Medicare Advantage plans; 25 percent of all Medicare beneficiaries were in MA or another private Medicare plan.[15] (See the Glossary for more.)

MEDIGAP INSURANCE

Medicare does not cover some important benefits. These include custodial long-term care, dental services and most vision and hearing services. Many people buy supplemental private insurance known as Medigap policies to cover benefits not covered by parts A, B and D and/or to cover the cost of the Medicare deductibles.

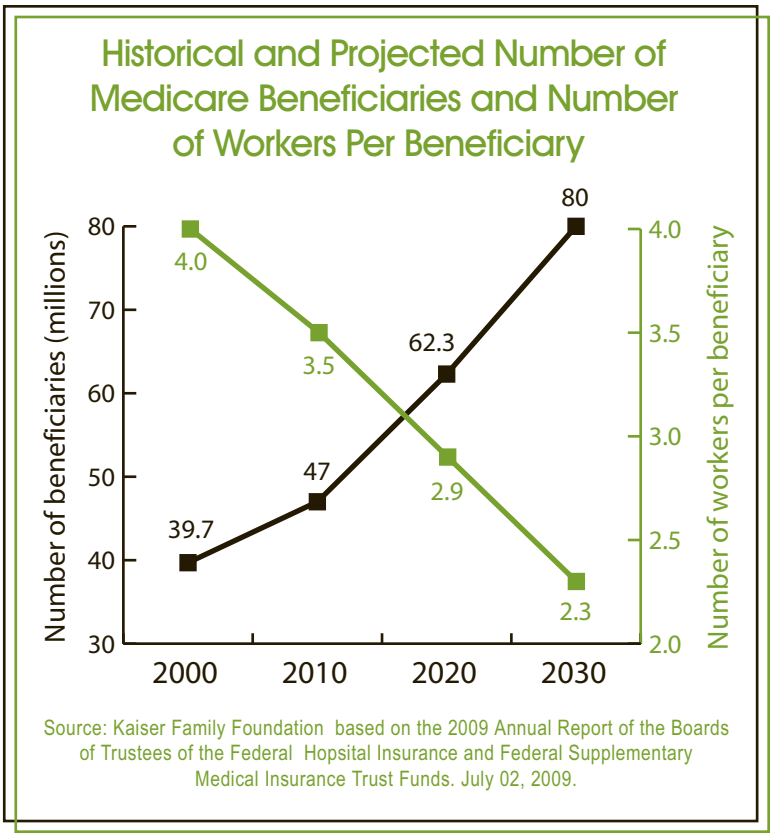
For a detailed description of what Medicare covers and how it is financed, go to the websites for the Medicare Rights Center (www.medicarerights.org) and the official U.S. government website for people with Medicare (www.medicare.gov).

MEDICARE FINANCING AND AN AGING POPULATION

Those seeking to assure adequate funding for both Social Security and Medicare face the problem that, with the aging of the population, there will be fewer workers supporting each retiree. (See chart, "Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary.") From 2010 to 2030, the number of beneficiaries is projected to rise from 47 million to 80 million, while the ratio of workers per beneficiary is expected to decline from 3.5 to 2.3.[16]

But Medicare has an added problem. Spending on health care has historically grown around 2.5 percentage points faster than the rest of the economy in real (that is, adjusted for inflation) per capita terms—something economists call the "excess spend" in health care. This excess spend will drive up future Medicare expenditures more than will the aging of the population.[17]

Medicare is projected to grow from 3.6 percent of GDP in 2010 to 3.9 percent in 2020 and 5.1 percent in 2030. According to the 2010 Medicare Trustees report, the Part A trust fund will be depleted in 2029.[18] (See chart, "HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures.")



HEALTH REFORM LEGISLATION AFFECTING MEDICARE

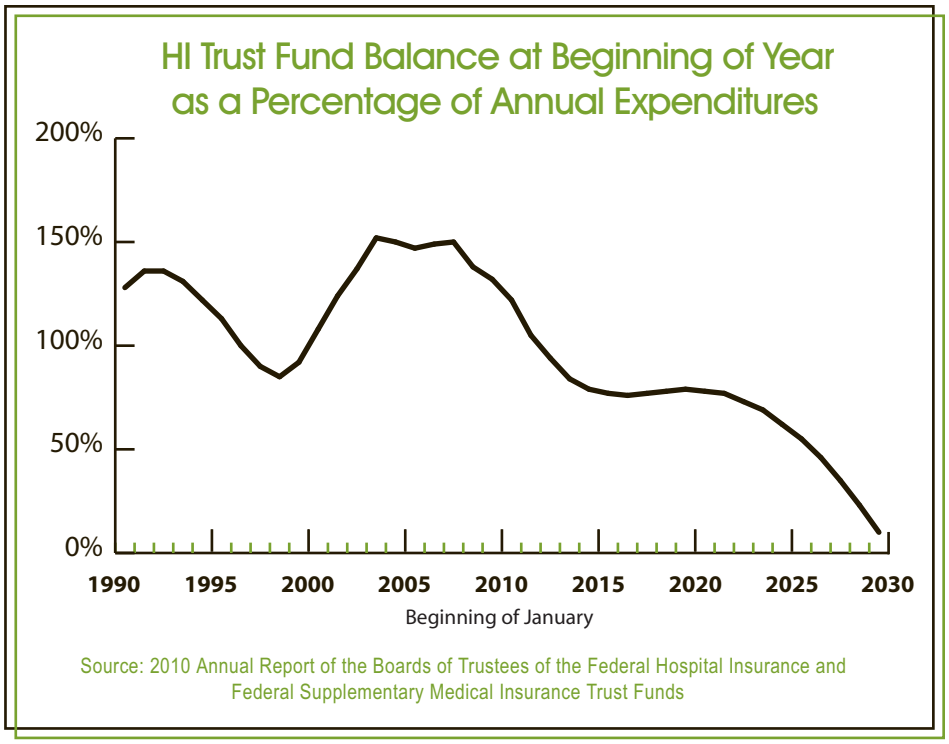
A number of changes in Medicare were made by the ACA. Modest expansions in benefits and some changes to assure access to care are included, as well as substantial reductions in provider and plan payment levels to achieve savings.

Key provisions of the legislation that affect Medicare are:

- A gradual elimination of the "doughnut hole" in the drug benefit.[19] In 2010, those who reached the doughnut hole, about 4 million beneficiaries, received a rebate from the federal government of $250.
- Beginning in 2011, a gradual phase-in for different levels of subsidies for brand name and generic drugs in the gap.[20, 21]
- The beneficiary liability in the doughnut hole will diminish from 100 percent of spending to 25 percent by 2020.
- Elimination of cost sharing (i.e., out-of-pocket spending) for preventive services[22] and access to

a comprehensive health risk assessment.[23]

- A10 percent bonus payment for primary care services, [24] effective January 1, 2011 and continuing through December 31, 2015.[25]
- A 10 percent bonus to general surgeons practicing in health professional shortage areas from 2011 to 2015, and extra payments in 2011 and 2012 to hospitals in the lowest quartile of Medicare spending.
- A downward restructuring of payments to Medicare Advantage plans by setting those payments as a share of Medicare fee-for-service rates.[26]
- Reduction of market basket updates (used to establish annual increases in payments) for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers.
- Creation of an Independent Payment Advisory Board to submit legislative proposals for reducing the per capita rate of growth of Medicare spending.
- A freeze on the threshold for income-related Medicare Part B premiums for 2011 through 2019 (increasing the number of beneficiaries subject to that premium) and the addition of an income-related premium to the Medicare Part D program.
- Creation of the CMS Center for Medicare and Medicaid Innovation to test, evaluate and expand different payment structures, models and methodologies for care delivery and chronic care management. (For more information, please see Chapter 2: Costs.)
- Creation of a Federal Coordinated Health Care Office to improve integration of care for dual-eligibles, those who qualify for both Medicare and Medicaid.



LIKELY POLICY DEBATES

These new legislative changes are likely to remain controversial and subject to debate as they are phased in over time. In addition, some lingering problems, particularly with physician payment, were not addressed in the ACA and will be on the agenda for further legislation.

Whether the Medicare Advantage changes will be allowed to remain

Reductions in payments to MA plans are likely to result in fewer extra benefits to those who enroll in these plans. These extra benefits have been popular with those who choose MA plans and there is likely to be debate over whether to sustain them over time. In addition, the savings from the formula change are an important revenue source in the law.

Whether the cuts in payments to Medicare providers can be achieved without harming the program

The Office of the Actuary of the U.S. Department of Health and Human Services, in a 2010 paper, raised concerns about whether it will be possible or desirable to attain the savings being sought from the Medi-

care program in the future.[27] In testimony before the House Committee on the Budget in early 2011, these concerns were reiterated. The Chief Actuary stated, "… the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future."[28]

There is likely to be continuing discussion about whether the Medicare changes can be successfully implemented over time, especially as the fate of the law is discussed in "repeal and replace" debates.

What to do with the sustainable growth rate (SGR) that limits spending on Part B, and more broadly, how to reform physician payment

This important area of Medicare payment was not addressed by the ACA, largely because it is likely to be very costly to resolve. In 2010, physician fees under Medicare were scheduled to be reduced by about 21 percent because spending on Part B of Medicare has exceeded the SGR over a number of years. (See text box, "Medicare's Sustainable Growth Rate Formula.") Congress adopted a number of temporary "fixes" over the years. In December 2010, Congress approved a one year provision keeping physician payment rates steady through 2011.[29]

The President's fiscal year 2012 budget proposes an additional two year extension up to September 2013 to be paid for by savings from health program integrity, efficiency and accountability.[30] Congress and the president need to agree on whether and how to change the SGR and how to change physician reimbursement to reward physicians who provide high quality services.

What to do about the dwindling trust fund and the sustainability of Medicare. (See chart "HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures.")

With the graying of the U.S. population and rising costs in health care generally, will the program as we know it be sustainable? The ACA increases the Medicare Hospital Insurance (Part A) payroll tax on earnings for higher-income taxpayers (more than $200,000/individual and $250,000/couple) by 0.9 percentage points from 1.45 percent to 2.35 percent, beginning in 2013, to be deposited into the Part A Trust Fund.[31] Will there need to be more adjustments to the formula? Are politicians in either party willing to tamper with this popular and successful program by changing the way we pay for it, reducing benefits or attaching means tests to premiums or eligibility for benefits? The debt reduction task force of the Bipartisan Policy Center recommended several actions for the short and long term to control Medicare costs and sustain the program for future generations. These include raising premiums in the short term and reducing per beneficiary federal support beginning in 2018.[32] Likewise, the President's National Commission on Fiscal Responsibility and Reform noted the need to look at Medicare as an apt deficit reduction target.[33]

TIPS FOR REPORTERS

- Some people confuse Medicare with Medicaid. Medicare is the federal program for people over 65 and certain people with permanent and severe disabilities. Medicaid is a federal/state program for certain low-income people.
- A small number of people are on both Medicare and Medicaid. They are called "dual eligibles" and spend a disproportionately large share of Medicare money. For more, see www.cms.gov/DualEligible.
- "End of life" care is always controversial. From 27 to 31 percent of Medicare dollars are spent during the last 12 months of a person's life.[34] This share has been relatively constant for several decades.[35]
- Medicare physician fees have been held at about the same level over most of the decade, but spending on Part B of Medicare has been increasing at 10 to 12 percent per year. This reflects changes in the volume and mix of services that have been provided and is a good reminder that setting prices is not the same as controlling expenditures.
- Medicare pays for primarily acute care events, although it does provide 100 days of nursing home care following a hospitalization. Most nursing home care is paid for either by Medicaid or directly by individuals, not by Medicare. [See chapter 9 on Long-term Care]

- For most services, Medicare covers 80 percent and the beneficiary co-pay is 20 percent. However, because Medicare provides no coverage at all for some items, like dental care, eyeglasses or hearing aids and it provides minimal long-term care, Medicare pays just under half (48 percent, or $8,344) of the $17,231 in average total medical and long-term care expenses per beneficiary in fee-for-service Medicare.[36] Beneficiaries pay 25 percent of this total out of pocket, including premiums.

STORY IDEAS

- Following the November 2010 midterm elections, has there been talk by representatives from your state about privatizing Medicare? Are seniors in your community open to this kind of change to Medicare? Do they think it would save money or cost more? Do they favor Medicare being administered by the federal government even if they are opposed to greater involvement of government in health care overall?
- Is there evidence of Medicare fraud and abuse by providers in your state? If so, what is being done about it? How much does fraud and abuse cost the program? Can beneficiaries help to prevent Medicare fraud and abuse? How?
- Are Medicare beneficiaries concerned about the health reform law? Are they confused about what it will mean for them, their benefits and their premiums? Where do they go for reliable information about how they will be affected?
- Medicare Advantage plans may be changing the benefits they offer because of the changes that will be made in payments to the plans. They may also change the premiums they charge, and the networks of providers they offer. Beneficiaries are traditionally reluctant to change plans, but there is likely to be much more reason to shop around before the next open enrollment period. Are they looking more carefully at their options since the new law was enacted? Has there been any movement away from Medicare Advantage plans back to traditional Medicare since enactment of the ACA?
- Are Medigap policies changing to meet the new requirements for first dollar coverage of preventive services? Are these policies being marketed differently, more aggressively in your area?
- Some experiments and demonstrations are likely to be undertaken by Medicare. One of these may be the medical home—where primary care physicians are given higher payments for providing more comprehensive care to their patients to help them better coordinate their treatment needs. Are there demonstrations being announced in your area? Are patients aware of and interested in these demonstrations? Are primary care physicians encouraged by these changes?
- Open period for beneficiaries to change their outpatient prescription drug plans is November 15 to March 31 of each year. How many seniors actually change plans? Ask them why they changed plans.
- Physician access is always an issue – particularly when physician fees are being held almost constant and under threat of reduction. Are seniors in your area having trouble getting appointments with physicians? With new physicians that they haven't previously seen? With primary care physicians? With specialists? Any indication this is actually occurring, as opposed to predictions that it will occur?
- What are seniors doing to improve their own health? Are they exercising, including walking regularly? Are there problems in their home or neighborhood that make it difficult for them to stay healthy?

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[23] Medicare.gov. "Preventive Services." http://goo.gl/CcJSf

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CHAPTER 8

MEDICAID

Originally written by Lisa Swirsky, Alliance for Health Reform, and updated by John Holahan, Urban Institute, and by Deanna Okrent, Alliance for Health Reform.

FAST FACTS

- Medicaid covered health and long-term care services for nearly 68 million low-income beneficiaries in March 2009.[1]
- There were 7.9 million individuals with disabilities and elderly people who made up 24 percent of those enrolled in Medicaid in 2009 and cost the program 63 percent of its total expenditures.[2]
- One half or approximately 34 million Medicaid beneficiaries were children in 2009.[3]
- Medicaid is the nation's primary payer for long-term care and pays for more than half of publicly financed mental health services.[4]
- Medicaid is projected to total $447 billion in 2011 in combined federal and state spending.[5]
- The Patient Protection and Affordable Care Act of 2010 (ACA) provides for a substantial expansion of Medicaid, to 16 million new beneficiaries.[6]

See p. 91 for story ideas and p. 92 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=124

BACKGROUND

Medicaid was signed into law in July 1965. It has since undergone a number of changes and enhancements, yet remains essentially an entitlement program for low-income individuals, administered by each state and financed jointly by each state and the federal government. It is authorized under Title XIX of the Social Security Act and initially was enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. In 1981, freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were mandated; and states were required to make additional payments to hospitals treating a disproportionate share of low-income patients (called disproportionate share hospitals or "DSH"). Other program nuances were established by law over the years, including the Qualified Medicare Beneficiary (QMB) eligibility rule in 1988, and the Specified Low-Income Medicare Beneficiary (SLMB) eligibility group in 1990 (see below for more about QMB and SLMB).[7]

States choose to participate in Medicaid, but must accept certain federal rules and must cover certain groups if they are to receive federal Medicaid funding. They must, for example, provide certain mandatory benefits such as inpatient hospital services, laboratory and x-ray services, and physician services.[8] Medicaid also mandates a benefits package for children known as Early and Periodic Screening, Diagnostic and Treatment.[9] And, federal law requires every state to provide nursing home care and home health care for the qualified poor. This results in Medicaid paying for nearly half of long-term care.[10] (See Chapter 9, "Long-Term Care," for more.)

Prior to the 2014 implementation of the Medicaid expansion provisions of the health care reform law of 2010 (see below), states must cover:

1. Poor families that meet financial requirements for cash welfare benefits in effect in 1996;
2. Families for one year after transitioning from welfare to work;
3. Pregnant women and children under age six with incomes below 133 percent of the federal poverty level (FPL);
4. Children ages six through 18 with income below 100 percent of the poverty level; and
5. Poor disabled or elderly persons who qualify for cash assistance under Supplemental Security Income (SSI).[11]

States can voluntarily choose to cover other groups, such as pregnant women and infants between 133 percent and 185 percent of FPL and certain categorically qualified individuals whose medical expenses have made them medically needy.[12]

MEDICAID SPENDING

Medicaid expenditures grew by 9.9 percent in 2009, to $380.6 billion; $250.9 billion or 66 percent represented federal spending, and $129.7 billion or 34 percent represented state spending.[13] This was the fastest annual growth rate since 2002. Analysts attribute the growth to rapidly increasing Medicaid enrollment among nondisabled children and adults as a result of many losing employment. Comparatively high growth rates in Medicaid spending and enrollment were expected to continue in 2010.[14] Growth rates beyond 2010 are expected to average 8.3 percent per year over the next 10 years. Total Medicaid expenditures are projected to reach $840.4 billion in 2019.[15] These projections reflect the significant increase in Medicaid enrollment that is anticipated to occur in 2014 as a result of the expansion of Medicaid eligibility under the 2010 health reform law.

More than half of Medicaid spending is attributable to five percent of the enrolled population – those with the greatest care needs.[16] And although children made up 50 percent of the Medicaid population in 2009, they accounted for only 22 percent of costs. Non-elderly adults, who made up 27 percent of Medicaid beneficiaries, accounted for just 16 percent of the costs.[17]

In contrast, the elderly made up only 9 percent of the population, but accounted for 22 percent of Medicaid costs. Individuals with disabilities made up 15 percent of the Medicaid population but accounted for 41 percent of costs.[18] (See chart "Medicaid Enrollees and Expenditures by Enrollment Group, 2009.")

DUAL ELIGIBLES

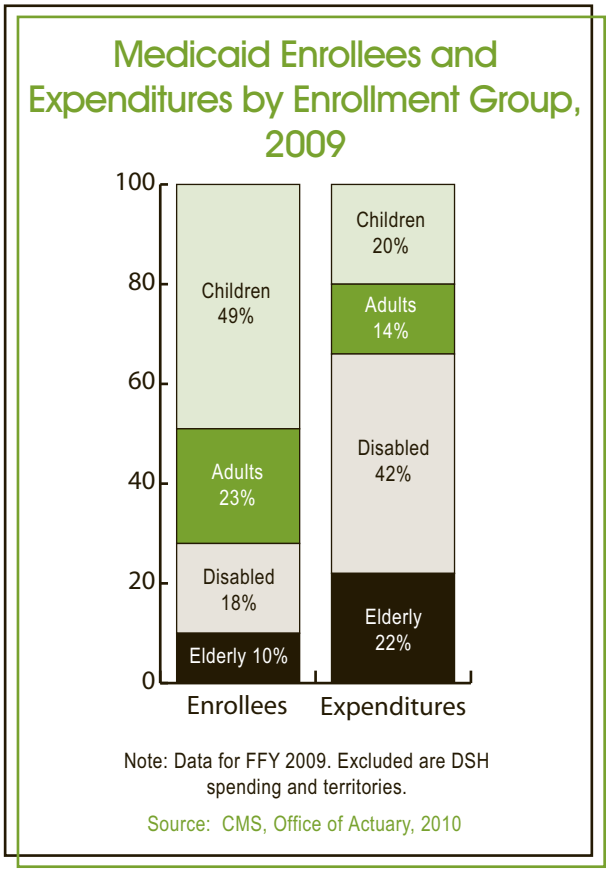
Much of Medicaid spending involves coverage for so-called "dual eligibles,"[19] individuals entitled to both Medicare and Medicaid. This population makes up 15 percent of Medicaid enrollees and accounts for 39 percent of Medicaid costs. Medicaid provides coverage that wraps around Medicare to individuals who are eligible for full Medicaid coverage. Medicare is the primary payer for the acute care benefits that both programs cover, with Medicaid paying the difference up to the state's payment limit for a given service. About 60 percent of dual eligibles are over the age of 65,[20] contributing to the fact that much of the Medicaid spending by dual eligibles is on long-term services.[21]

There are other benefits for Medicare beneficiaries entitled to some – but not full – Medicaid benefits. These benefits, collectively called the Medicare Savings Program, provide help with a variety of out-of-pocket costs. *The Qualified Medicare Beneficiary program (QMB or "Quimby")*, one part of the Medicare Savings Program, pays for Medicare premiums, deductibles and coinsurance for people with incomes below 100 percent of the federal poverty level (FPL) and with resources two times the standard allowed under the Supplemental Security Income program.

Specified Low-Income Medicare Beneficiaries (SLMB or "Slimby") have their Medicare Part B premiums paid if they are between 100 and 120 percent of the FPL and have resources at or below twice that allowed under SSI. (Part B pays for doctors.) Qualifying individuals can get help with their Part B premiums if they are between 120 and 135 percent of the FPL. However, this benefit is not an entitlement; states receive a limited amount of money from the federal government.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE

The federal government reimburses states for a part of their Medicaid program expenses. The federal share, known as the federal medical assistance percentage (FMAP), differs from state to state, based on state per capita income. In FY 2008, states received a share as low as 50 percent of total spending or as high as 76 percent.[22]



The FMAP temporarily increased, however, by 6.2 percentage points for each state under the American Recovery and Reinvestment Act passed by Congress and signed into law in early 2009. Some states with substantial increases in unemployment qualified for additional FMAP increases.[23] The increase remains in effect through the "recession adjustment period" which was originally scheduled to end December 31, 2010 but was extended through June 2011.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (ACA)

The Patient Protection and Affordable Care Act (ACA) signed by President Obama on March 23, 2010, provides for a considerable expansion of Medicaid.[24] States must expand Medicaid to all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The law will primarily affect parents and childless adults.

The financing of the reform is somewhat complex. Currently, states receive federal assistance based on a sliding scale, where the percentage of program costs paid by the federal government (the FMAP described

above) is higher for lower-income states.

States will receive their current matching rate for those who are currently enrolled in the program and those eligible under pre-reform criteria who take up coverage after the Medicaid reforms kick in in 2014.

For those who are newly eligible under the ACA, states will receive a very high matching rate; federal funding for these individuals will be 100 percent for 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter. States that have already expanded eligibility to childless adults will receive a higher FMAP that will increase each year so that by 2019 they receive the same federal financing, 90 percent, as states receive for new eligibles.

Second, states that expanded coverage to childless adults beginning on April 1, 2010 will receive their regular FMAP for these individuals until 2014. This provision may be particularly attractive to states that were covering large numbers of childless adults under a state-funded program.

Third, the law will increase Medicaid payments for providers in family medicine, general internal medicine, or pediatric medicine who provide primary care in fee-for-service and managed care practices. Rates will increase to 100 percent of Medicare payment rates for 2013 and 2014; these increased payment rates are 100 percent federally financed.

Fourth, states are required to maintain current Medicaid (and Children's Health Insurance Program) eligibility levels for children until 2019, and maintain current Medicaid eligibility levels for adults, until the new health insurance exchanges are fully operational. (See Chapter 1, "Health Reform" for details.)

Established under the CHIP reauthorization of 2009 and later expanded and funded under ACA is the Medicaid and CHIP Payment and Access Commission (MACPAC). This entity is designed to review policies and make recommendations to Congress, the Secretary of Health and Human Services (HHS), and the states on a wide range of issues affecting Medicaid and CHIP populations, including health care reform.[25]

The ACA establishes two new federal entities – the Federal Coordinated Health Care Office (FCHCO – also known as the "Office of Duals") and the Center for Medicare and Medicaid Innovation (Innovation Center, or CMMI) – that will be involved in efforts to study and improve care for dual eligible beneficiaries.[26] The Innovation Center announced a new initiative that will fund state demonstration projects. These projects, which will be implemented beginning in 2012, will examine programs that fully integrate care for dual eligibles.[27]

LIKELY POLICY DEBATES

The expansion of Medicaid to adults with income up to 133 percent of the federal poverty level under the ACA will mean large increases in enrollment in many states. Because of the very high federal matching rates available to states for new enrollees, new state financial burdens will be relatively low initially. However, the administrative burden of large increases in enrollment is likely to be significant. Are states equipped for those new responsibilities? A number of states made mid-year budget cuts to close shortfalls for FY 2011. States have implemented various Medicaid cost containment strategies including provider rate cuts, benefit restrictions, provider assessments and administrative cuts.[28]

Medicaid enrollees often cycle in and out of the program as their employment and subsequently their income status changes. Once the state insurance exchanges are operational in 2014, how will the Medicaid program coordinate these cyclical changes with individuals' ability and eligibility to purchase insurance on the exchange? To qualify for subsidies? Creating a seamless system may be the subject of much debate about who or which state agency should be in charge of such enrollment issues and how they will coordinate with federal agencies determining subsidies.

The financing of Medicaid will be a significant issue in the upcoming debates over the deficit and entitlement reform. All efforts to contain the growth in costs will be explored. The debt reduction task force of the Bipartisan Policy Center recommended several actions that would include cuts to Medicaid.[29] In the short term, the task force recommended that Medic-

aid apply managed care principles in all states to aged Supplementary Security Income (SSI) beneficiaries. In the longer term they proposed a federal-state negotiation to allocate program responsibilities between the federal government and the states, so that each would fully finance and administer its selected components of the Medicaid program. The task force asserts that this would restore incentives for cost containment, and slow future program spending growth.

Likewise the National Commission on Fiscal Responsibility and Reform has also listed Medicaid as a deficit reduction target.[30] Some Medicaid advocates have expressed concerns that cuts to Medicaid would affect the most vulnerable populations, especially older adults.

TIPS FOR REPORTERS

- Make sure you understand the difference between Medicaid and Medicare, especially with regard to long-term care. Medicare covers some nursing home care and home health care but usually these follow hospitalization. The true long-term care services that are provided to the chronically ill are financed by Medicaid. Read the Medicare and long-term care chapters in this sourcebook for details.
- State financing for Medicaid is complicated. For example, financing of Medicaid can refer to Medicaid spending for your state, including federal Medicaid funds, or Medicaid spending using state only funds, not including federal matching funds. It is also important to realize that Medicaid financing often substitutes for uncompensated care provided to the uninsured. Uninsured patients who are not covered by Medicaid would become financial burdens to hospitals and clinics and much of that care is financed with state and local taxes.
- Most states contract with managed care organizations to provide coverage to beneficiaries. What contractual obligations between the state and the insurer exist to ensure quality of care? How are these obligations enforced? How will managed care change with health reform?
- Dual eligibles are a constant point of contention between federal and state governments. Be sure to sort out what state and federal obligations are toward these individuals and whether the respective obligations are being met. Follow the progress of the newly created "office of duals" especially with regard to its funding and recommendations.
- Be mindful of which groups and services are mandated to be covered by Medicaid and which groups and services are covered at your state's option. Coverage for voluntary groups varies significantly from state to state, while mandatory coverage is the same across states. The same is true for benefits.

STORY IDEAS

- How has the serious recession and slow recovery affected your state's ability to maintain existing Medicaid benefits and provider reimbursement rates? The ARRA provided states with additional matching funds but has required states to maintain the current eligibility levels. How did your state use these funds? What are they doing now that the enhanced FMAP from ARRA is scheduled to end in June 2011? Is your state cutting Medicaid benefits to help balance their budgets? Are they seeking a waiver from maintenance-of-effort requirements?
- What level of uptake is there in your state for QMB or SLMB? Is there a special effort to reach qualifying potential beneficiaries?
- How are access to care and quality affected by the relatively low payment levels that Medicaid sets for hospitals, physicians and other providers? What percentage of physicians in your state accepts Medicaid patients? Do these physicians have practices made up largely of Medicaid patients?
- What strategies is your state pursuing to contain Medicaid costs, improve efficiency, and improve quality?
- What impact are Medicaid budgetary problems having on safety net providers such as community health clinics and public hospitals? How will these safety net providers be affected by health reform?

- The ACA will provide for large – if temporary – increases in Medicaid physician payment rates. How do physicians expect to respond to these rates? Will there be greater physician participation in Medicaid? Will physicians be willing to care for patients who would otherwise be seen in community health centers and emergency rooms, thus reducing the net new costs of the higher payment rates?

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CHAPTER

LONG-TERM CARE

Originally written and updated by Deanna Okrent, Alliance for Health Reform.

FAST FACTS

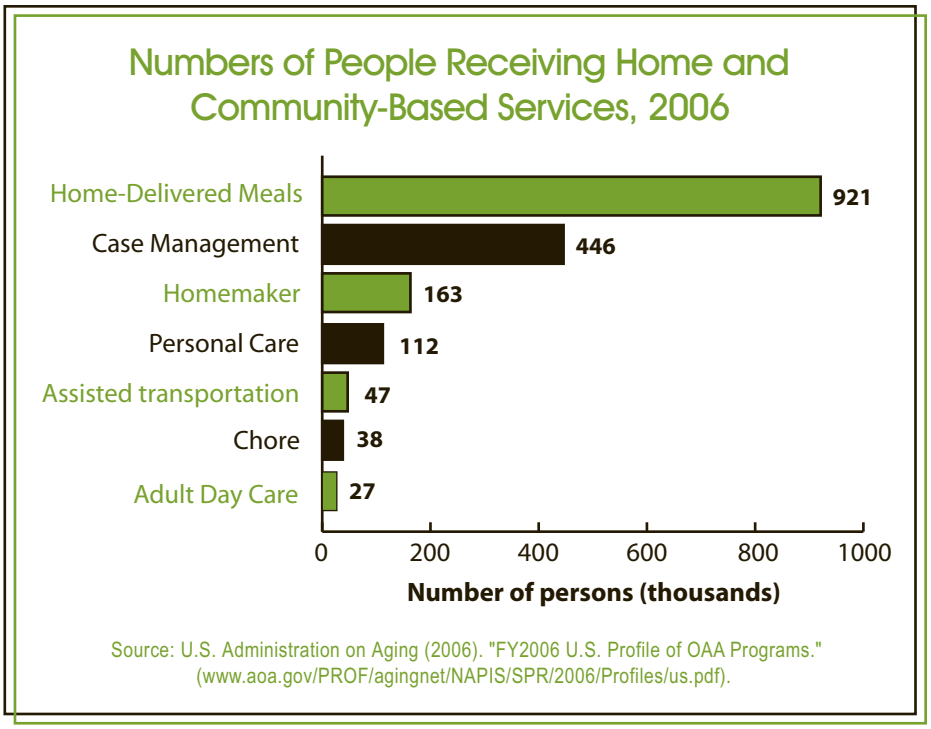
- 70 percent of people age 65 today will need some long-term care in their lifetimes.[1]
- Within 20 years, persons age 65 and older will comprise 20 percent of the U.S. population.[2]
- Of the 10 million Americans who need assistance with daily activities, 1.7 million live in the nation's 16,000 nursing homes and approximately 520,000 live in assisted living facilities.[3]
- Fourteen percent of Americans age 85 or older live in nursing homes.[4] A total of $207 billion was spent on long-term care in the U.S. in 2005.[5]
- Of total long-term care spending, Medicaid accounts for 49 percent, Medicare accounts for 20 percent, out-of-pocket spending equals 18 percent and private health and long-term care insurance make up 7 percent,[6] and provide the majority of long-term care services.
- There are 52 million unpaid caregivers who contribute an estimated $375 billion in value to the U.S. economy and provide the majority of long-term care services.[7]
- The Community Living Assistance Services and Supports (CLASS) Act, enacted in the Affordable Care Act (ACA), establishes a new voluntary long-term care insurance program that will be federally administered.[8]
- ACA also establishes new home and community-based services options and provides incentives to states to institute them as part of several changes to Medicaid.

See p. 100 for story ideas and also for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=125

BACKGROUND

Boomers start turning 65 in 2011. To put this in perspective, in the next 10 years, the number of Americans age 65 and older will increase by 35 percent to 55 million. By 2030, that number will more than double to 71 million and will comprise roughly 20 percent of the U.S. population.[9]

Though they are working longer, living longer and leading more active lives than did their parents, roughly 70 percent will need long term care (LTC) services – their chances increasing as they age – in their lifetime.



Long-term care comes in many different forms and is provided in many different settings. These include institutional care, assisted living and home – and community-based services – including home health care, adult day care, home delivered meals and other services authorized under Title III of the Older Americans Act.[10] (See chart, "Numbers of People Receiving Home and Community-Based Services, 2006.")

These services are financed by Medicaid, Medicare, private long-term care insurance, private out-of-pocket spending and appropriations under the Older Americans Act.

The majority of long-term care services aren't paid for at all. They are provided by 52 million unpaid caregivers – primarily family members and friends of those needing LTC. Their services, if paid for, would have cost an estimated $375 billion in 2007 – almost double what the federal government spent that year on Medicaid.[11, 12]

Cost of Institutional Long-term Care

In 2009, the average annual cost of a private room in a nursing home was close to $80,000.[13] The average cost for an assisted living facility in 2009 was $37,572.[14] (See Glossary for the differences between the two.) These costs vary widely from region to region and are highest in the Northeast.[15] Costs also vary by certification status, size and type of ownership of the facility.

FINANCING LONG-TERM CARE

MEDICAID

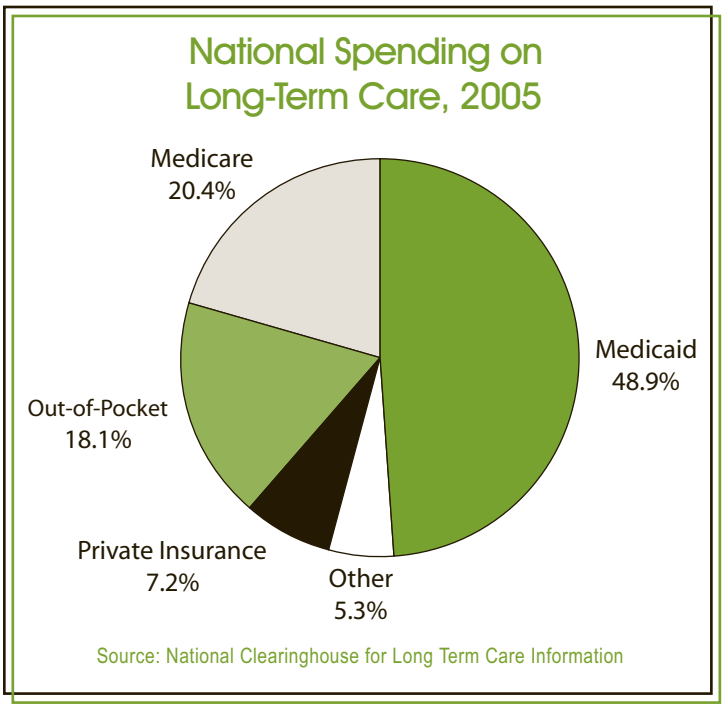
Medicaid accounts for almost half of national long-term care spending.[16] (See chart, "National Spending on Long-Term Care, 2005") Of that amount, most is for institutional care, though spending for non-institutional care is growing and reached 37 percent of Medicaid's share of LTC spending in 2005.[17] Though over half of those who use Medicaid long-term care services are over 65, a third (34 percent) are disabled children and adults under 65.[18] (See chart, "Nursing Home Residents by Age & Gender.")

NATIONAL SPENDING ON LONG TERM CARE

Under Medicaid, every state must provide nursing home care and home health care for the qualified poor. Medicaid LTC benefits vary from state to state.

The Deficit Reduction Act (DRA) of 2005, added the Money Follows the Person Program (MFP) to fund transitions out of nursing facilities, and the Home and

Community Based Services (HCBS) State Plan Benefit program. These types of programs began to shift Medicaid's focus from institutional care to HCBS.The health reform law of 2010 (The Patient Protection and Affordable Care Act, or ACA) contains provisions that continue the shift from institutional care to home and community-based services. It expands the MFP program and the HCBS State Plan Benefit program and establishes a new HCBS benefit that states may offer under Medicaid, the Community First Choice Option. The law also initiated a Medicaid State Balancing Incentive Payments Program that will give financial incentives to states to expand existing HCBS programs and increase the percentage of persons who receive long-term services through HCBS.[19] As of Oct 1, 2010, individuals no longer have to meet an institutional level of care requirement in order to qualify for HCBS.[20]



MEDICARE

Though many people think that Medicare covers long-term care, in reality it provides only limited coverage of nursing home stays and home health care. Eligibility is based on, and must follow, a hospital stay of at least three days. Medicare covers short-term stays in skilled nursing facilities – full coverage for 20 days, partial coverage for up to 80 additional days. This spending, plus spending for home health benefits for eligible Medicare beneficiaries, accounts for 20 percent of long-term care expenditures.[21]

PRIVATE LONG-TERM CARE INSURANCE

A relatively small number of people purchase long-term care insurance – approximately 7 million policies were in force in 2005.[22]

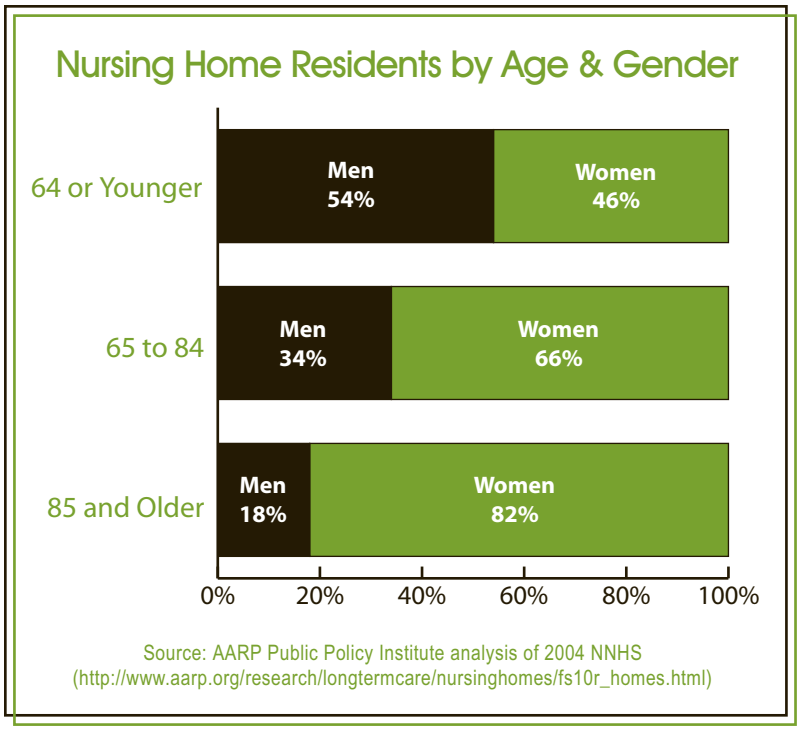
The Robert Wood Johnson Foundation, in 1987, initiated an experimental program called the Program to Promote Long-Term Care Insurance. Also referred to as the Partnership Program, it involves a public-private partnership between Medicaid and private insurance. Those buying long-term care insurance can protect a portion of their assets that otherwise would count against them were they to apply to Medicaid to cover their long-term care expenses. (See the Alliance for Health Reform issue brief on this topic at http://goo.gl/Hx9Ai.)

The Partnership Program began as a demonstration project in four states and is now available for replication in all states. Forty-four states implemented or are in the process of implementing Partnership Programs as of June 2010; 37 states have policies available for purchase.[23] All told, long-term care insurance pays for approximately 7 percent of national long-term care spending.[24]

CLASS ACT

The Community Living Assistance Services and Supports (CLASS) Act, enacted in the ACA, establishes a new voluntary long-term care insurance program that will be federally administered. Individuals will be automatically enrolled if their employers agree to participate and premiums will be paid through payroll deductions unless an individual opts out.[25] Though this feature makes participation easy, the program is not projected to make an immediate, sizable difference in the insurance rolls. One of the risks of a voluntary program is that of adverse selection. Will only those people enroll who are more likely to need the services? Will the program be sustainable or the premiums affordable, if that is the case?

Others are concerned about the net federal costs of the program. The CMS Office of the Actuary[26] estimates a net Federal savings for the CLASS program of $38



billion during the first 9 years of operations. These savings will decline once benefit payments begin, the Actuary concluded. Projections for the long term, 2025 and beyond, indicate that benefit payments will exceed premiums and the program will result in a net cost. Concerns about this eventuality are leading some to seek repeal of the CLASS Act provision in the ACA. Others would be satisfied with substantial revisions to the program.

Many details of the new program have yet to be determined by the Secretary of Health and Human Services, such as the premiums and the benefit schedule. The Secretary is expected to define the CLASS benefit by October 2012 with enrollment to begin subsequently.[27] What has been announced already is the opening of the Office of CLASS within the Administration on Aging and that the program will be administered by the Assistant Secretary of Aging.[28]

OUT-OF-POCKET SPENDING

For people without insurance, including those who do not qualify for Medicare or Medicaid benefits, long-term care costs are paid out-of-pocket. Out-of-pocket spending accounts for 18 percent of national spending for long-term care.[29]

LIKELY POLICY DEBATES

FINANCING

Provisions in ACA contain incentives that may shift services from institutions to home and community-based alternatives. This may help state budgets hold up under the strain of their large Medicaid long-term care expenses. It remains to be seen whether the provisions in ACA alter the ratio of institutional care to home and community-based services and if so, what effect this might have on nursing homes and on state budgets.

Perhaps private long-term care insurance can play a greater role. How can we increase its appeal and thereby its market share? Are consumer protections needed to allay fears that the insurance policies of today will cover the needs of tomorrow? Will new products be marketed to supplement the voluntary long-term care insurance program in the CLASS Act?

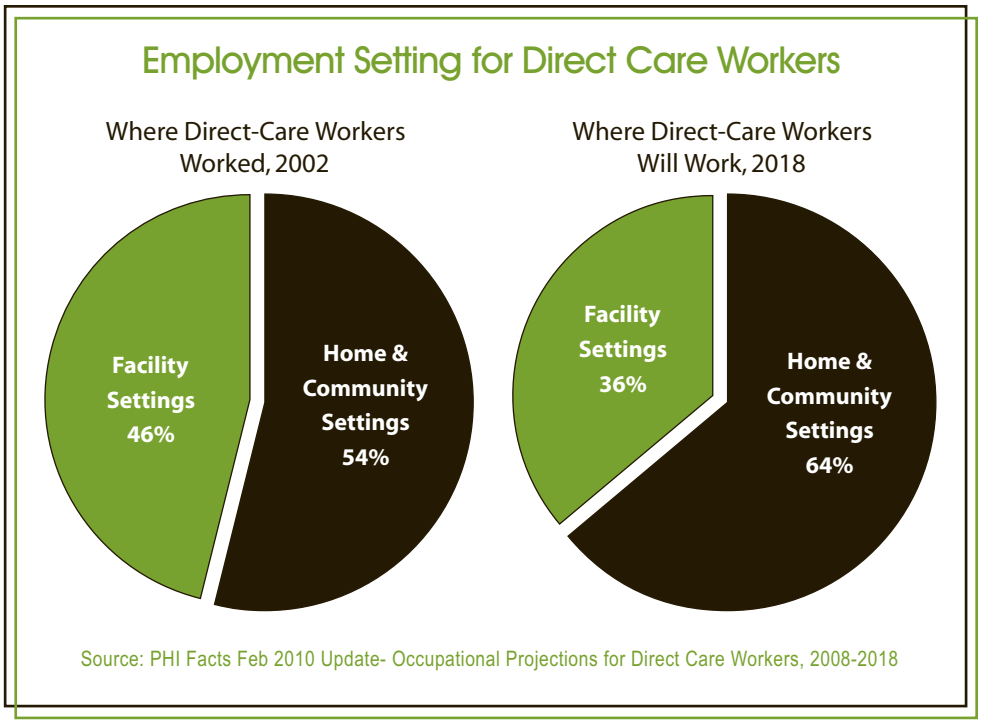
WORKFORCE

Throughout the health care arena there is a workforce shortage[30] and this is dramatically so for direct care workers in long-term care.[31, 32] Studies have shown that quality of care is directly related to nurse staffing ratios,[33] yet in very few states does the average staffing ratio meet the minimum standard recommended by each state. Questions abound on how to increase recruitment, retention and job satisfaction of direct care workers. The biggest question is: Will the workforce supply be ready to meet the baby boomer demand?

The majority of direct-care workers are no longer employed by facilities. They are employed in home and community-based settings. This shift in employment setting is expected to continue and it is projected that home and community-based direct care workers will outnumber facility workers in 2018 by nearly two to one (see chart, "Employment Setting for Direct Care Workers).[34]

QUALITY OF CARE AND RESIDENT-DIRECTED CARE AND SERVICES

In 2007, nearly 17 percent of nursing homes inspected by state regulators were cited for serious deficiencies.[35] Some say the inspection system is broken.[36] Others say quality of care is the issue, and that nursing home ownership is a contributing factor[37] (with most of the criticism lodged against certain for-profit chains). ACA provisions require disclosure of ownership and governance.[38]



Some new models of care are being demonstrated across the country to improve quality of care.

Among these is the Green House® model, which provides person-centered long-term care in small home-like settings as an alternative to larger, institution-like nursing homes. (For more, see the Alliance issue brief "Changing the Nursing Home Culture" at http://goo.gl/N7zeS.)

Studies have shown improved resident and caregiver satisfaction at these types of facilities.[39]

DISPARITIES

A 2007 study showed a relationship between racial segregation and quality disparities in U.S. nursing homes.[40] The study found that blacks were more likely to live in poor quality nursing homes than whites. Blacks were almost three times as likely to live in a nursing home housing predominantly Medicaid residents. The study offered policy recommendations including Medicaid payment reform that would close the gap between Medicaid per diem rates and those paid by private payers, and broader regional planning.

TIPS FOR REPORTERS

- It is a common misperception that Medicare covers long-term care. It is not well understood that the Medicare "long-term care" benefit is limited to 100 days of skilled care and that it must follow a hospital stay of three days or more. The Center for Medicare Advocacy has information about skilled nursing facility (SNF) care, therapy care, rehab care, and other Medicare issues on its web site, www.medicareadvocacy.org. You can also learn about Medicare benefits at www.cms.gov.
- It is not well understood that Medicaid covers long-term care for qualified individuals and that it is a means-tested benefit. Most publicly funded long-term care is financed by Medicaid.
- Gifts to family members or others within the five-year period prior to applying for Medicaid count as assets of the potential beneficiary for purposes of determining Medicaid eligibility. The period in which such gifts are counted as assets is known as the "look-back period." It is commonly asserted that individuals divest themselves of assets in order to qualify for Medicaid and be eligible for long-term care coverage. However, studies have found little evidence of this phenomenon.[41]

- The movement to resident-centered care or person-centered care is often linked with the Green House® movement. (NCB Capital Impact, with support from the Robert Wood Johnson Foundation, is pursuing the development of Green Houses across the country. See NCB Capital Impact's website at http://goo.gl/WhaSi for more information about this replication initiative.) However, resident-centered care can occur in all long-term care facilities, not only ones of a particular architectural design. This movement has many shapes and forms depending on developments on the local and state level and subject to state and federal regulations. A good resource for information about this movement is www.pioneernetwork.net. The movement is also known as "culture change."
- Many long-term care facilities require residents to sign admissions agreements with mandatory arbitration clauses. There have been successful cases challenging the legality of such clauses. However, it is still a common occurrence. It is also common to request that a family member accept financial responsibility for their loved one in the facility. Family members are not required to accept such responsibility but often don't realize what they have signed until much later down the road.

STORY IDEAS

- Is your state conducting an ACA-funded training demonstration for certified nurse assistants (CNAs) to bolster the long-term care workforce? Are there tangible results in lower turnover rates and higher job satisfaction?
- State Medicaid budgets have been greatly affected by the economic downturn. Have benefits in some areas been cut to maintain the long-term care safety net for the poor? Will families be able to continue their out-of-pocket spending for long-term care? Will Medicaid long-term care services swell? (For more information on Medicaid and state budgets see the Kaiser Family Foundation's report "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011" at http://goo.gl/YQYqb.)
- Are innovative models of care gaining market share? How is the Green House® project progressing in your area? Has the economic downturn hampered capital projects and slowed progress toward changing institutional models of care into more home-like settings?
- Are current HCBS sufficient to meet the increased demand? Are the incentives in ACA effectively changing the bias from institutional care to more HCBS? Are new models developing? Are they public-private partnerships or do they depend solely on Medicaid funding? Are some traditional nursing facilities facing diminishing occupancy rates and being forced to close their doors?
- What effect will the CLASS Act have on the long-term care insurance market? Are people in your community talking about the CLASS program? Are they interested in participating once enrollment begins? Do they think it's a good way to prepare to meet their future long-term care needs? What other ways are they preparing for such an eventuality?

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CHAPTER 10

DISPARITIES

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FAST FACTS

- More than one-third of those in the U.S. identify themselves as racial and ethnic minorities.[1] This number is expected to climb to more than half of the population in 2042.[2]
- As many as 83,000 deaths each year are attributed to racial and ethnic health disparities.[3]
- The annual National Healthcare Disparities Report, published by the federal Agency for Healthcare Quality and Research, has consistently shown that blacks and Latinos suffer from poorer quality care and worse access to care than whites on a number of indicators.[4]
- Hispanics are half as likely as whites to have a regular source of care.[5]
- Infants born to non-Hispanic black women are almost two and a half times more likely to die than infants born to non-Hispanic white women.[6]
- Native Americans and Alaska Natives are more likely than whites to lack prenatal care in the first semester.[7]
- Rates of preventable hospitalization increase as income decreases.[8]
- The Patient Protection and Affordable Care Act of 2010 contains a number of provisions that could help reduce racial and ethnic disparities in care.[9]
- Reaching the objectives set out by Healthy People 2020 would dramatically reduce racial and ethnic disparities in access to care.[10]

See p. 110 for story ideas and p. 111 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=125

BACKGROUND

More than one-third of those in the U.S. identify themselves as racial and ethnic minorities.[11] This number is expected to climb to more than half of the population in 2042.[12] As so-called minorities collectively become the majority of the U.S. population, we can expect Congress, state governments and localities to give more and more attention to their health needs.

Certainly, more attention is warranted. Disparities in health care of racial and ethnic minorities in the U.S. vs. non-Hispanic whites have persisted for decades, despite the earnest efforts of health services professionals, governments and non-government groups. The annual National Healthcare Disparities Report, published by the federal Agency for Healthcare Research and Quality, has consistently shown that blacks and Latinos suffer from poorer quality of care and worse access to care than whites on a number of indicators.[13]

The latest report paints a gloomy picture. A decided majority of core quality measures did not improve in 2010 vs. 2009 for blacks, Asians and American Indians/Alaska Natives compared with whites. The same was true for Hispanics compared with non-Hispanic whites.[14]

Turning to access to care, researchers found that a majority of core measures did not improve for blacks and American Indians/Alaska Natives compared with whites, or for Hispanics compared to non-Hispanic whites. However, a majority of access measures did improve for Asians compared to whites.[15] (See chart, "Access and Quality Measures Not Improving for Various Racial and Ethnic Groups, 2010 vs 2009.")

CAUSES OF DISPARITIES

Disparities are attributed to a number of factors. Where a person lives, what language she speaks, and her household income are only some of the characteristics that can contribute to differences in the way different racial and ethnic minorities receive care.

WHERE YOU GET YOUR CARE

While research suggests that some providers treat racial and ethnic minorities differently than whites, there is growing evidence that some disparities are largely the result of where minorities receive care.

One study looked at 123 teaching hospitals and found clear disparities in the treatment of minorities. When the researchers dug deeper, they concluded that "an underlying cause of disparities may be that minority patients are more likely to receive care in lower performing hospitals."[16]

It seems that patients at a particular hospital are treated similarly, regardless of race. But minority patients are more likely than whites to go to hospitals that may have been short-staffed, had inadequate budgets or lacked technical support. Supporting this view, another study looking at hospital inpatient discharge data from 13 states found that blacks, Hispanics and Asians received the same standard of care as whites within the same hospitals.[17]

HEALTH INSURANCE STATUS

Uninsured people and those with inadequate insurance are more likely to have worse quality of care and poor health outcomes than those with adequate insurance.[18] One of every three Hispanics and one of five blacks were classified as uninsured in 2009, compared to 12 percent of non-Hispanic whites.[19] Hispanics, who comprise 16 percent of the U.S. population, accounted for 30 percent of the uninsured in 2009.[20] (See chart, "People Without Health Insurance by Race, 2009" and "Uninsured Children by Race, 2009.")

The Patient Protection and Affordable Care Act (or ACA, for short) will reduce the number of uninsured people in the U.S. by 32 million,[21] the Congressional Budget Office (CBO) estimates. This will help minorities who are U.S. citizens or in the U.S. legally. But the law will not affect access to care for undocumented immigrants. CBO estimates that of the 23 million likely to remain uninsured in 2019, 7 million will be undocumented immigrants.[22]

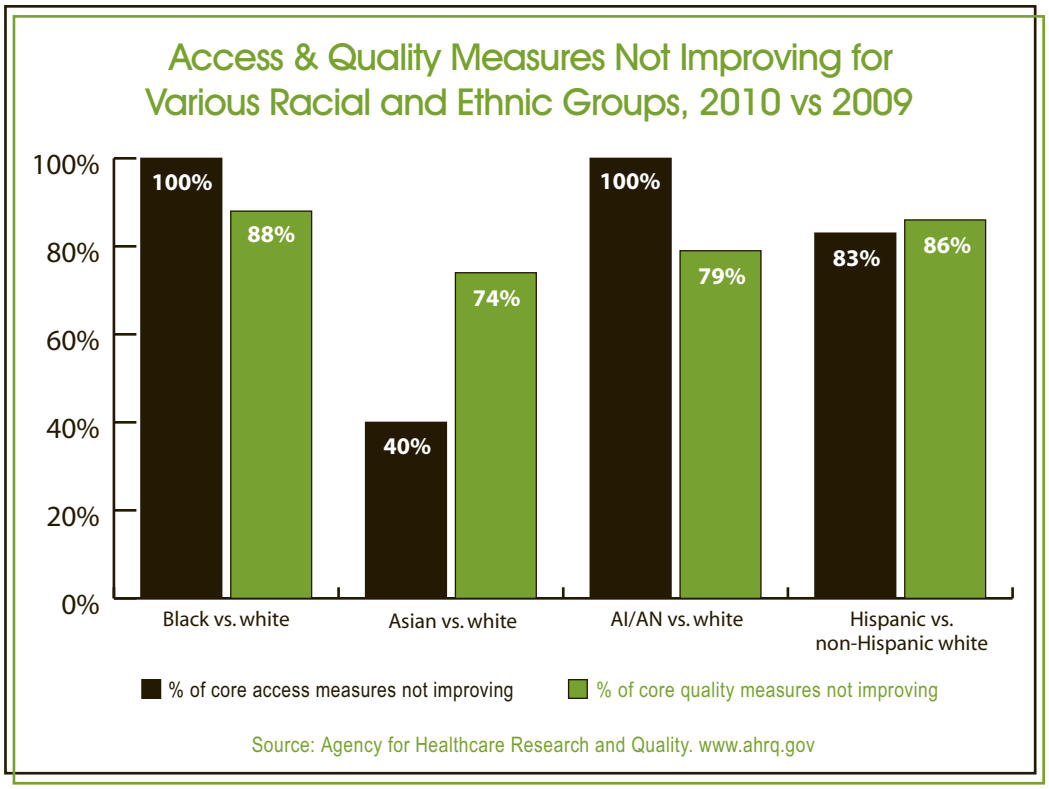
Healthy People 2020, a far-reaching effort led by the U.S. government, has a goal of health coverage for all in the U.S. by 2020.[23]

LANGUAGE ACCESS BARRIERS

Linguistic and cultural barriers are another significant

impediment to health care for those who don't speak English well, or at all.

More than 24 million people in the U.S. have limited English proficiency. More than 55 million people, almost one person is five, speak a language other than English at home.[24,25] (See text box, "Selected Languages Other Than English Spoken at Home, 2010.")



Along with impeding communication between health care provider and patient, linguistic and cultural barriers contribute to the underutilization of available services. They also make it hard for patients to adhere to recommended care, and lead to negative patient experience and reduced quality of care.[26]

Federal laws, some going back decades, attempt to reduce these problems. These include the Hill-Burton Act and Title VI of the Civil Rights Act, which says that any organization receiving federal funds must ensure access to the group's programs and services for individuals with limited English proficiency.

In 2000, the Department of Health and Human Services Office for Civil Rights issued "Standards for Culturally and Linguistically Appropriate Services" which include a requirement that health care organizations must have bilingual staff, interpreters and other "language assistance services" available.[27]

In addition, all states and the District of Columbia have laws on the books designed to make access to health care easier for those speaking a language other than English.[28]

SOCIOECONOMIC STATUS

In addition to race and ethnicity, other factors contribute to disparities in care. Research demonstrates a positive correlation between socioeconomic status (SES) and health status. Those with higher income, education or occupational status tend to have better health status than others.[29] And blacks and Hispanics on average have lower income and less education than do whites.[30] As income decreases, rates of preventable hospitalizations go up.[31]

Another factor in racial disparities may be access to a "medical home," an approach to care in which patients are assigned to a physician or other primary care provider who is in charge of coordinating care among the many physicians and specialists that a patient might see.

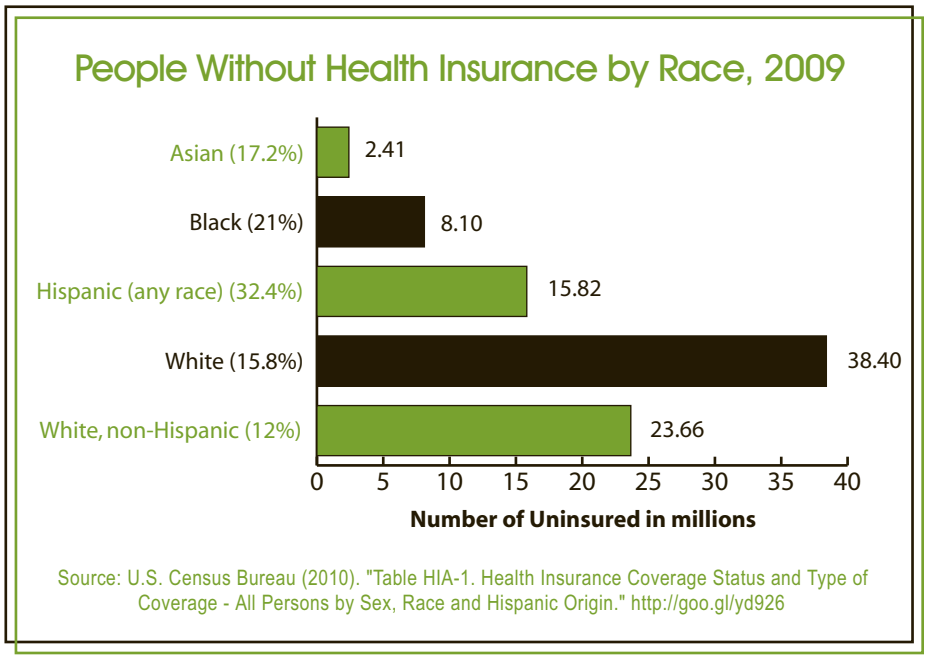
The Affordable Care Act encourages medical homes through a program of grants and contracts[32] and provides extra compensation for care delivered through medical homes.[33]

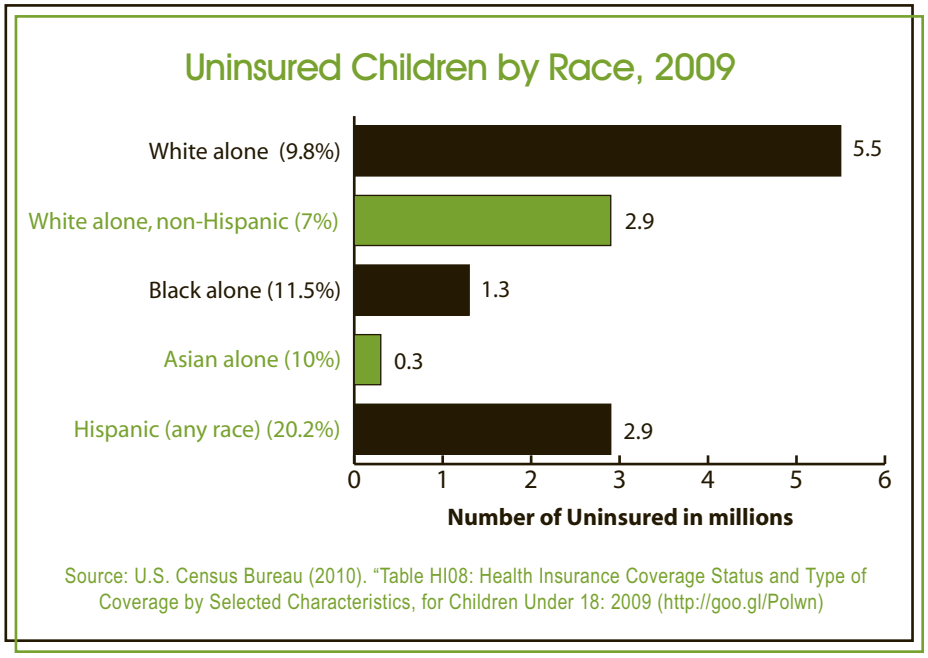
OTHER FACTORS

Some researchers believe physician behavior can contribute to disparities.[34] Studies have found evidence of provider racism in the treatment of patients

in cardiac care, for example.[35, 36] A 2009 study found that blacks being treated for high blood pressure have shorter visits with their physicians and less patient – physician communication than do whites.[37]

Housing segregation is a major contributor to disparities. For minorities, this leads to reduced opportunities for socioeconomic advancement, negative health behaviors, and more exposure to environmental hazards and segregated health care settings. Socioeconomic status does not completely account for housing segregation; blacks and Latinos have more limited choices of neighborhoods because of housing discrimination.[38] Blacks are more likely to report being in poor health if they live in a neighborhood that is highly segregated racially.[39]





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HEALTH REFORM AND DISPARITIES

The Affordable Care Act contains several provisions that could help reduce disparities, in addition to dramatically increasing the number of people with health coverage:[40]

- *Workforce diversity and cultural competency* – The law offers encouragement for greater ethnic and racial diversity in the health professions. It also improves cultural competency training for health care providers. Health plans will be required to use language services in underserved communities.
- *Preventive care* – The law requires Medicare and some private insurance plans to cover recommended preventive services such as check-ups, cancer screenings and immunizations without any additional out-of-pocket payments from patients.
- *Chronic disease management* – The law offers incentives for providers grouping themselves into coordinated care teams, called Accountable Care Organizations, that can better manage chronic conditions than individual practitioners. This will be helpful to minorities, who have a higher risk than whites for conditions such as diabetes, kidney disease, heart disease and some cancers.

Selected Languages Other Than English Spoken at Home, 2010.

Language	# who speak this language at home (in millions)	# of those in Col. 1 who speak English less than "very well" (in millions)	% of those in Col. 1 who speak English less than "very well"
All languages other than English	55.1	24.25	44.0%
Spanish	34.2	16.1	47.2%
Chinese	2.5	1.4	55.8%
Tagalog	1.4	0.5	31.6%
French	1.4	0.3	21.5%
Vietnamese	1.2	0.7	60.7%
German	1.1	0.2	17.6%
Korean	1.0	0.6	58.2%
Arabic	0.8	0.3	34.7%

Source: U.S. Census Bureau (2010). "Language Use." Table 1, Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for the United States." (www.census.gov/hhes/socdemo/language/index.html)

- *Coverage for those with pre-existing conditions* – Every state now has a new program offering insurance at affordable rates for those with pre-existing health conditions, as long as they've been uninsured for at least six months.
- *Community health centers* – The ACA increases funding for community health centers, which care for people regardless of their ability to pay.
- *Data collection* – The law requires collection and reporting of data on race, ethnicity, sex, primary language and disability status. It also requires collection of data on access to care and treatment for people with disabilities.[41] (See text box "Racial and Ethnic Data Collection" for more discussion.)

LIKELY POLICY DEBATES

MEDICARE PROVIDER PAYMENTS

Congress is moving to make Medicare provider payment more dependent on quality and less dependent on volume of services delivered. While such a payment change is likely critical in order to promote sustainable high quality care, some researchers think these kinds of payment reforms could inadvertently aggravate disparities by reducing income to providers in minority communities.[42]

For example, the 2006 Tax Relief and Health Care Act established a voluntary physician quality reporting system for the care of Medicare patients.[43] The ACA extended this system beyond 2010. In addition, the ACA provides incentives for providers who group themselves into Accountable Care Organizations and meet quality targets.[44] The president's deficit reduction commission report calls for payments to doctors "based on quality instead of quantity of services."[45] The unintended consequences of reforming Medicare payments might be addressed by implementing payment strategies that reward physicians both for improvement over time as well as for their absolute quality scores. Provider payments could take into account poorer health status in minority communities and reward providers for reduction of disparities.[46]

TIPS FOR REPORTERS

- What is your state government doing to address the issue of disparities? For a synopsis of state laws dealing with assisting non-English speakers in health care settings, go to http://goo.gl/EiOmY.
- Don't overlook private sector activities around the issues of disparities. What are health plans doing to collect and analyze data on race and ethnicity, and how are they using these data to

Racial and Ethnic Data Collection

Those hoping to reduce racial and ethnic health care disparities depend on accurate data to help them identify specific problems and subgroups facing them. Toward this end, there have been some efforts to standardize the way race and ethnicity data are collected. The Office of Management and Budget, for example, has determined basic racial and ethnic categories for federal statistics and programs.[1]

Despite this determination, federal programs face many barriers in obtaining this type of information. Medicaid, a joint state and federal program, must rely on states for race and ethnicity data, but states vary in the ability of their information systems to collect them. States tend to collect the data from enrollees on a voluntary basis, often offering a limited number of race and ethnicity categories. As a result, the data are often incomplete.[2]

At the hospital level, research suggests that there are gaps in the collection and standardization of race and ethnicity data across hospitals.[3] Health information technology may be one avenue for improving the standardization of data on race, ethnicity and language data. Standardized use of electronic health records systems to capture patient data related to race, ethnicity and language could dramatically enhance the ability to identify and monitor care disparities.

The American Recovery and Reinvestment Act signed into law by President Obama in Feb. 2009 ensures that data are collected on race, ethnicity and primary language.[4] As noted above, the ACA goes farther. It requires collection and reporting of data on race, ethnicity, sex, primary language and disability status. It also requires collection of data on access to care and treatment for people with disabilities.[5]

But questions remain. Will the new data collection requirements be followed? What will government and public sectors entities do with the data? Will the enhanced data collection make a difference in reducing disparities?

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2 Karen Lamos and Lindsay Palmer (2006). "Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries." Center for Health Care Strategies June, p. 1. http://goo.gl/kNQR2
3 Siegel, Bruce; Regenstein, Marsha; Jones, Karen (2007). "Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care."January. http://goo.gl/AtnlB See also: Lin C.J.; Musa, D.; Silverman, M. (2003)."Is Managed Care a Potential Source of Racial Disparities in the Use of Preventive Care?" http://goo.gl/FvDD0
4 American Recovery Act of 2009, Title XIII, §3002(b)(2)(B)(vii).
5 Kaiser Family Foundation. "Summary of New Health Reform Law." Pp. 8,9. http://goo.gl/fJOu8

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reduce disparities? What are private hospital systems and physician groups doing to address the issue of disparities? Has the Affordable Care Act's provisions on ethnic and racial data collection made a difference in how providers in your state are gathering such data?

- Monitor how racial and ethnic groups are categorized as the population becomes increasingly more diverse and as intermarriage between racial groups become more common. Are federal programs, state administered programs, health plans, hospitals and physicians adapting to demographic changes appropriately in their approach to disparities?
- Consider whether successful quality improvement strategies are being adopted by providers that serve minority populations? Are community health centers and public hospitals able to adopt IT systems that enable better quality improvement and care coordination?
- If you'd like to write stories about health disparities but your editor is less than enthusiastic, point him or her to a March 2009 survey by the Kaiser Family Foundation and the Association of Health Care Journalists (AHCJ). Among AHCJ members responding, 69 percent said U.S. news media in general give too little coverage to health disparities. In contrast, 52 percent said there's too much coverage of consumer/lifestyle health. Go to http://goo.gl/xChdE to see the survey and a webcast of its release.

STORY IDEAS

- Is the Affordable Care Act helping reduce disparities in your state?
- Would loosening restrictions on access to federal health programs for undocumented immigrants decrease disparities?
- What has happened during the recession to safety net providers (e.g., public hospitals and community health centers) – the places where minorities often receive care? What happens to those who gain insurance in a downturn as they become poor enough to qualify for Medicaid?

- Take a look at the annual National Healthcare Disparities Report put out by the Agency for Healthcare Research and Quality (www.ahrq.gov) and see how the data compare with those of previous years. The report usually comes out in Feb. or March.

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CHAPTER

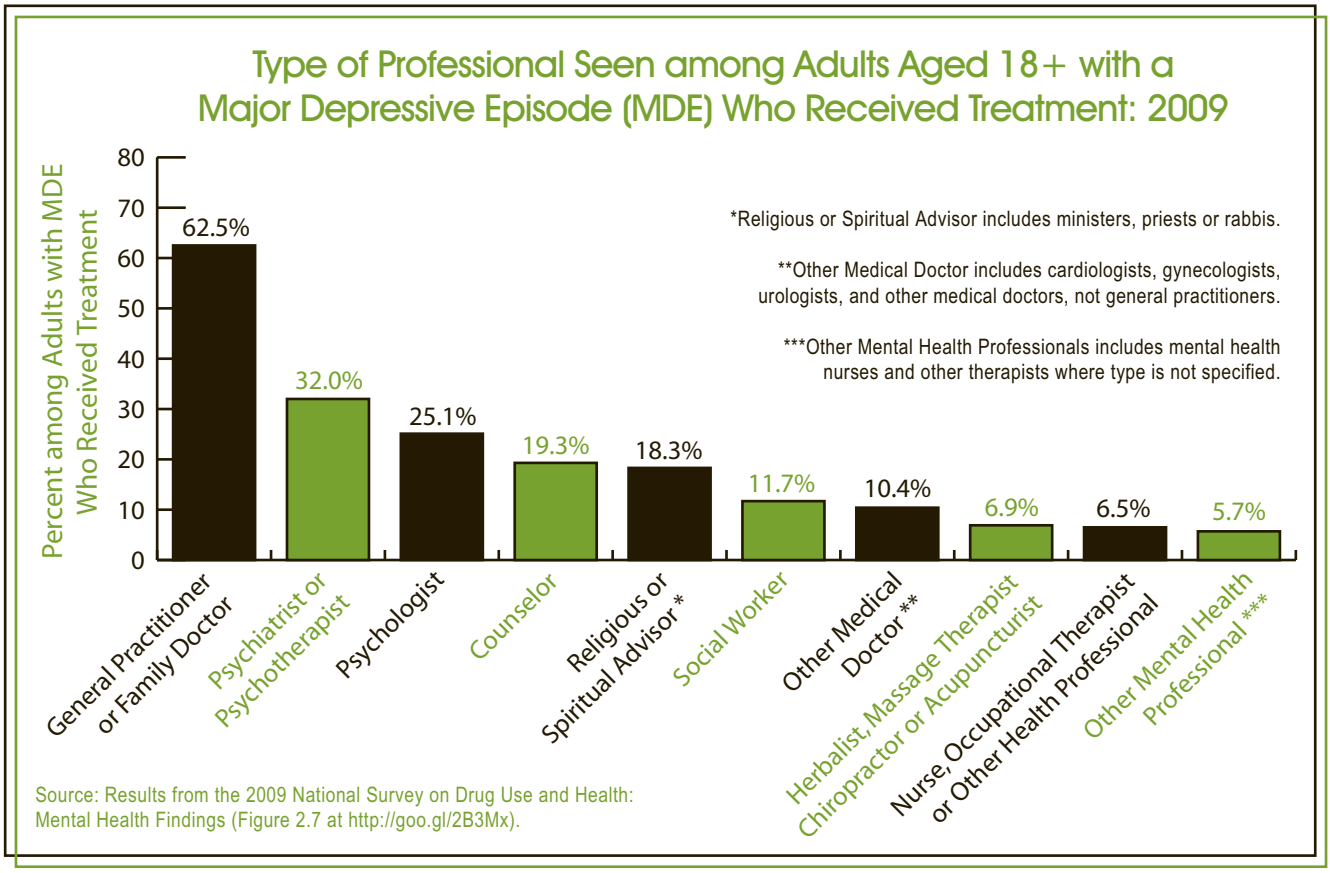
MENTAL HEALTH AND SUBSTANCE ABUSE

Originally written by Bill Erwin, Alliance for Health Reform, and updated by Bill Emmet, The Campaign for Mental Health Reform, and Bill Erwin.

FAST FACTS

- An estimated 45.1 million adults in the U.S. age 18 or older had any mental illness in 2009 (almost one out of five people in this age group).[1]
- In 2009, an estimated 17.1 million adults with a mental illness received any kind of mental health service during the past year. Among adults with severe mental illness, 60.2 percent received mental health services during the past year.[2]
- An estimated 12 million adults felt they needed mental health services but hadn't received enough mental health care in the past year.[3] Of those, 6.1 million had not received any mental health care in the past year.[4]
- Individuals out of work are four times as likely as those with jobs to report symptoms consistent with severe mental illness.[5]
- The cost of care is cited most often by people who recognize that they need mental health treatment but don't get it.[6]
- In 2009, an estimated 22.5 million persons aged 12 or older were classified as having substance dependence or abuse in the past year (8.9 percent of the population in this age group).[7] Of these, 3.2 million were classified as dependent on, or abusing, both alcohol and illicit drugs.[8]
- Marijuana was the most commonly used illicit drug in 2009, with 16.7 million people using in the past month. Nearly a quarter of the population aged 12 or older (23.7 percent) said they participated in binge drinking in the past month.[9] Binge drinking is defined as five or more drinks on the same occasion.[10]
- On January 1, 2010, most group health plans began implementing a law putting mental health and substance abuse treatment on a parity with treatment of medical and surgical conditions.[11]

See p. 121 for story ideas and also for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=127



BACKGROUND: MENTAL ILLNESS

Mental health problems are rising in the public consciousness, for several reasons. Many stories about the January 2011 shooting of U.S. Rep. Gabrielle Giffords focused on the mental instability of the shooter. Also, as many as 300,000 American military personnel have returned from the wars in Afghanistan and Iraq with post-traumatic stress disorder (PTSD), causing hardships for these individuals and their families.[12]

In addition, persistent unemployment caused by the recent recession has had mental health consequences. Jobless individuals are four times as likely as those with jobs to report symptoms of severe mental illness.[13]

About one out of five people in the U.S. aged 18 or older had any mental illness in 2009, according to the Substance Abuse and Mental Health Services Administration.[14] This is far more than the share of people ever told by a health professional that they had heart disease (12 percent) or cancer (8 percent).[15] In 2009, 17.1 million adults in the U.S. with any mental illness received mental health services during the previous 12 months (38 percent of that population). Some 28 million adults with mental illness did not receive any mental health services.[16]

The amount spent nationally to treat mental illness is hard to calculate, since so much mental health care is delivered by family physicians and general practitioners, perhaps secondarily to treatment for another non-mental condition. (See chart, "Type of Professional Seen among Adults Aged 18+ with a Major Depressive Episode (MDE) Who Received Treatment: 2009.")

The amount spent in 2003 has been estimated at $100.3 billion.[17] Between 1987 and 2006, treatment for mental health contributed more to the overall rise in Medicare spending than any of the other top-10 disorders.[18] In addition to the billions spent in treatment, mental illness also costs individuals and society in terms of lost productivity, lost earnings due to illness and social disruptions linked to mental problems.[19]

In their severity, mental illnesses range from occasionally troubling to life-consuming. (See text box,

"Some Major Categories of Mental Illness.") To cope with temporary problems, such as depression following illness or a traumatic event, many people need only a short-term intervention. But others experience more debilitating and long-lasting conditions that interfere with routine activities such as work, school, and family, and can require lifelong treatment. (See chart, "Adults Suffering Selected Mental Illness in a Given Year.")

Effective, well documented treatments for mental illness and substance abuse have been developed and widely disseminated, including psychotherapy regimens, other psychosocial treatment and prescription medications.[20]

But a significant number of Americans do not have adequate access to mental health treatment or do not take advantage of available help. The reason most often cited for not getting care was cost (42.5 percent).[21] (For other reasons, see chart, "Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with an Unmet Need for Mental Health Services: 2009.") By decreasing the number of uninsured individuals, the Affordable Care Act has the potential to remove costs as a barrier to getting mental health care.

BACKGROUND: SUBSTANCE ABUSE

Substance abuse involves the overuse of common products such as alcohol, pain relievers and tranquilizers, and also illegal drugs such as cocaine and heroin. An estimated 22.5 million people were substance dependent or substance abusers in 2009.[22]

Substance abuse and dependence vary considerably with age and gender.

Some Major Categories of Mental Illness

Anxiety Disorders
These disorders cause people to feel frightened, distressed and uneasy for no apparent reason. Left untreated, they can dramatically reduce productivity and significantly diminish an individual's quality of life. They include panic disorder, obsessive-compulsive disorder, post traumatic stress disorder, phobia and generalized anxiety disorder.

Bipolar Disorder
Bipolar disorder, also known as manic depression, is an illness causing a person's mood to swing from excessively "high" and/or irritable to sad and hopeless, with periods of a normal mood in between. The disorder typically begins in adolescence or early adulthood and continues throughout life. Although there is no known cure, bipolar disorder is treatable, and recovery is possible.

Depression
Depression – which can occur to anyone at any age -- causes people to lose pleasure from daily life, can complicate other medical conditions, and can even be serious enough to lead to suicide. Types include major depressive disorder, manic depression and dysthymia, a milder, longer-lasting form of depression. Clinical depression is very treatable, with more than 80 percent of those who seek treatment showing improvement.

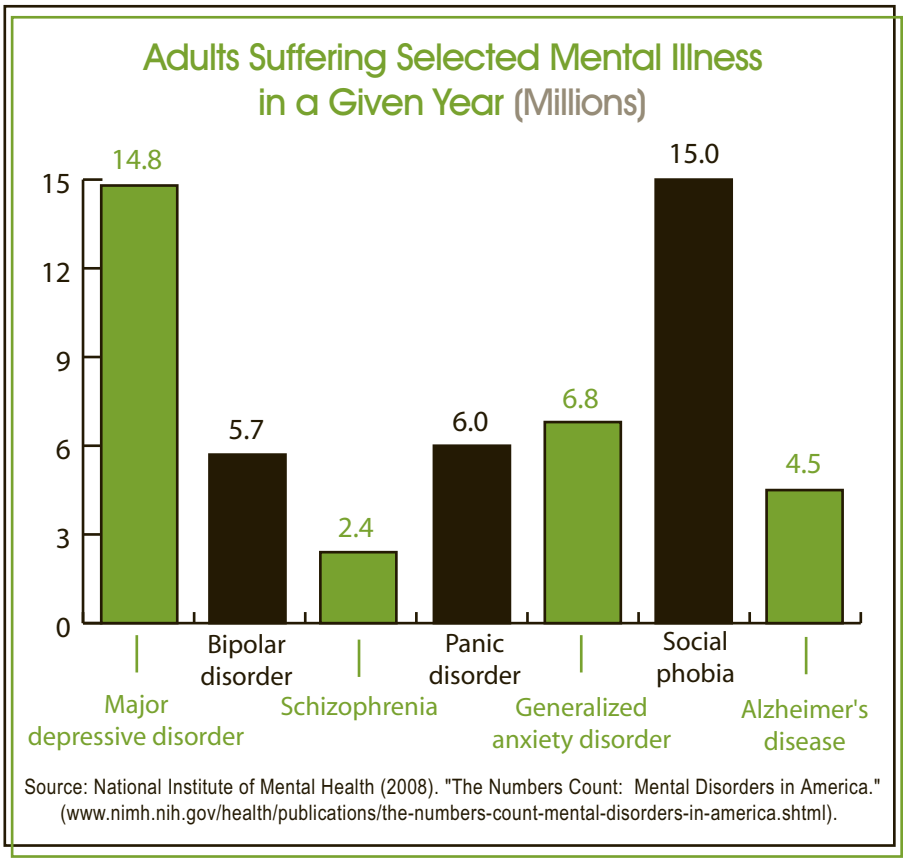
Schizophrenia
Schizophrenia affects how a person thinks, feels and acts. Someone with schizophrenia may have difficulty distinguishing between what is real and what is imaginary, may be unresponsive or withdrawn, and may have difficulty expressing normal emotions in social situations. While no cure for schizophrenia exists, many people with this illness can lead productive and fulfilling lives with early and proper treatment.

Dementias
Alzheimer's Disease is the most common cause of dementia in older people. A dementia is a medical condition that disrupts the way the brain works. Alzheimer's affects the parts of the brain that control thought, memory, and language. Although the risk of getting the disease increases with age, it is not a normal part of aging. At present, the cause of the disease is unknown and there is no cure. Multi-infarct dementia is the second most common cause of dementia in older people, and is sometime difficult to distinguish from Alzheimer's. Multi-infarct dementia is caused by a series of strokes that damage or destroy brain tissue, and usually affects people between 60 and 75 years old.

Eating Disorders
People with eating disorders experience serious disturbances in their eating patterns, such as a severe and unhealthy reduction in their food intake or overeating, as well as extreme concern about body shape or weight. Eating disorders are treatable illnesses usually developing during adolescence or early adulthood. The two main types of eating disorders are anorexia nervosa and bulimia nervosa. Extreme weight loss and believing that one is fat despite excessive thinness are key features of anorexia. People who have bulimia regularly binge-eat and then attempt to prevent gaining weight from their binge through purging (e.g., vomiting, abusing laxatives, exercising excessively).

Source: Mental Health America (www.mentalhealthamerica.net/go/get-info)

Among all people in the U.S. aged 18 to 25, one out of five (20 percent) was classified as substance dependent or substance abusing in 2009. In contrast, 7.3 percent of those older than 25 were abusers or dependent.[23] The rate for males is about twice as high as for females.[24]



Source: National Institute of Mental Health (2008). "The Numbers Count: Mental Disorders in America." (www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml).

Alcohol is the most commonly abused substance, with an estimated 18.6 million people aged 12 and older classified as abusing or dependent on alcohol in 2009.[25] Among illicit drugs, marijuana is abused most often (4.3 million people abusing or dependent).[26] (See chart, "Dependence on or Abuse of Specific Illicit Drugs in the Past Year among Persons Aged 12 or Older: 2009.") Other illicit drugs used include hashish, cocaine (including crack), heroin, hallucinogens, inhalants and psychotherapeutic drugs used nonmedically. An estimated 3.2 million people were dependent on, or abused, both alcohol and drugs.[27]

11

A relatively small number of substance abusers get treatment. In 2009, 4.3 million people aged 12 or older received any treatment related to the use of alcohol or drugs (19 percent of all abusers).[28] Among those who received treatment, a majority (58 percent – 2.5 million) got treatment at a self-help group. The next most commonly mentioned treatment site was an outpatient rehabilitation facility (46.5 percent – 2.0 million).[29]

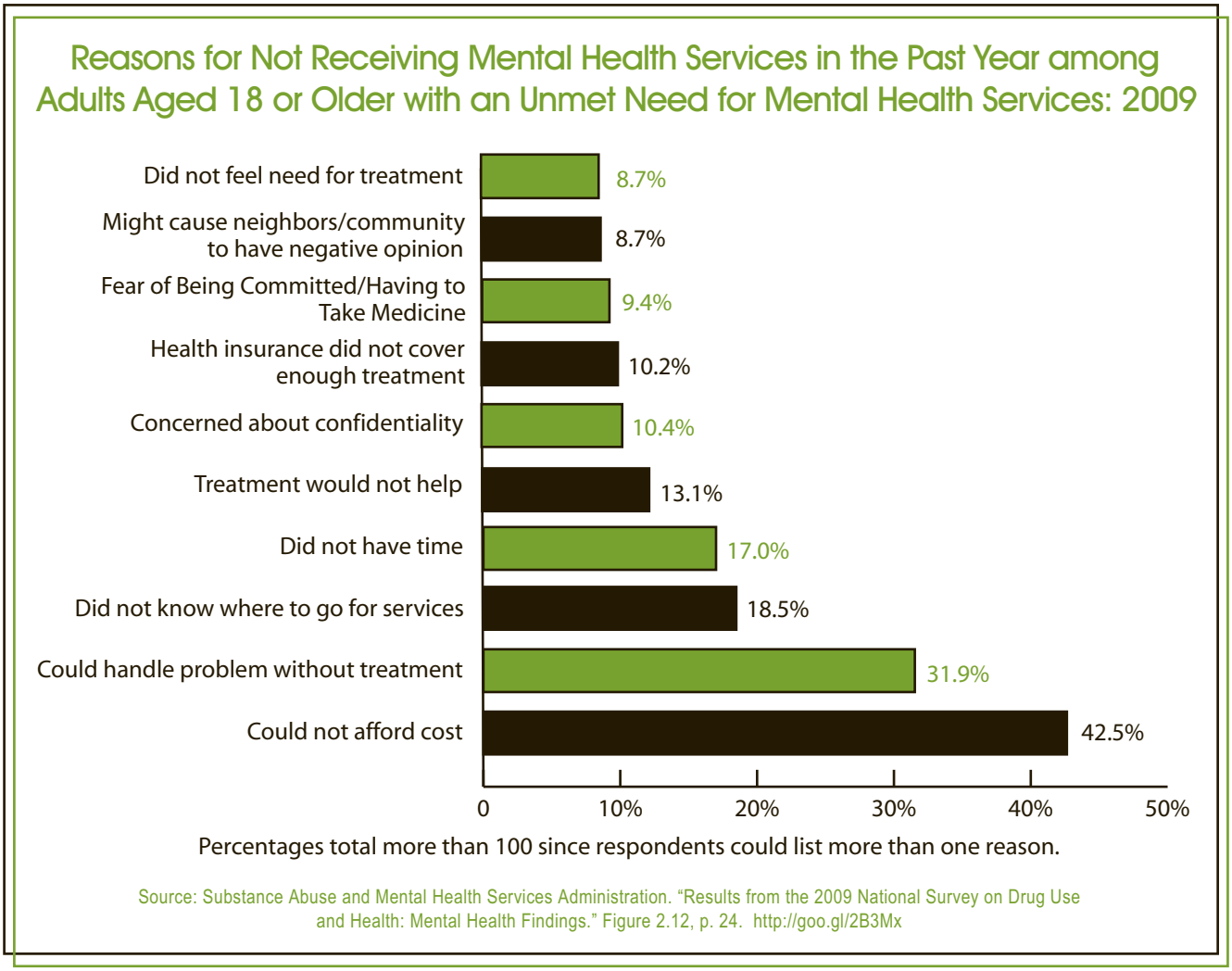
Almost 40 percent of those with a perceived need for illicit drug or alcohol abuse treatment who didn't get it, despite making an effort to do so, said they didn't have health coverage and couldn't afford the cost out of pocket.[30]

Drug and alcohol treatment centers are making efforts to overcome the difficulties people have in getting care. For instance, the Network for Improvement of Addiction Treatment (NIATx) has been helping such centers reduce the waiting time between a person's first request for service and his or her first treatment session by an average of 37 percent. NIATx also helps treatment centers reduce no-shows and keep their clients involved through at least the fourth treatment session.[31] The effort is supported by the Robert Wood Johnson Foundation and the federal Substance Abuse and Mental Health Services Administration.

CO-OCCURRING CONDITIONS

A significant number of individuals suffer from more than one problem at a time, such as mental illness and substance abuse, or mental illness and a chronic health condition. Mental illness is quite common, for instance, among Medicaid beneficiaries with chronic conditions. A 2010 study found that two-thirds of Medicaid beneficiaries with any one of five chronic physical conditions also had a mental illness.[32] In 2009, 26.5 percent of people with mental illness also used illicit drugs, more than double the 11.6 percent of people using drugs who did not have mental illness.[33]

When a person with a mental condition also has a



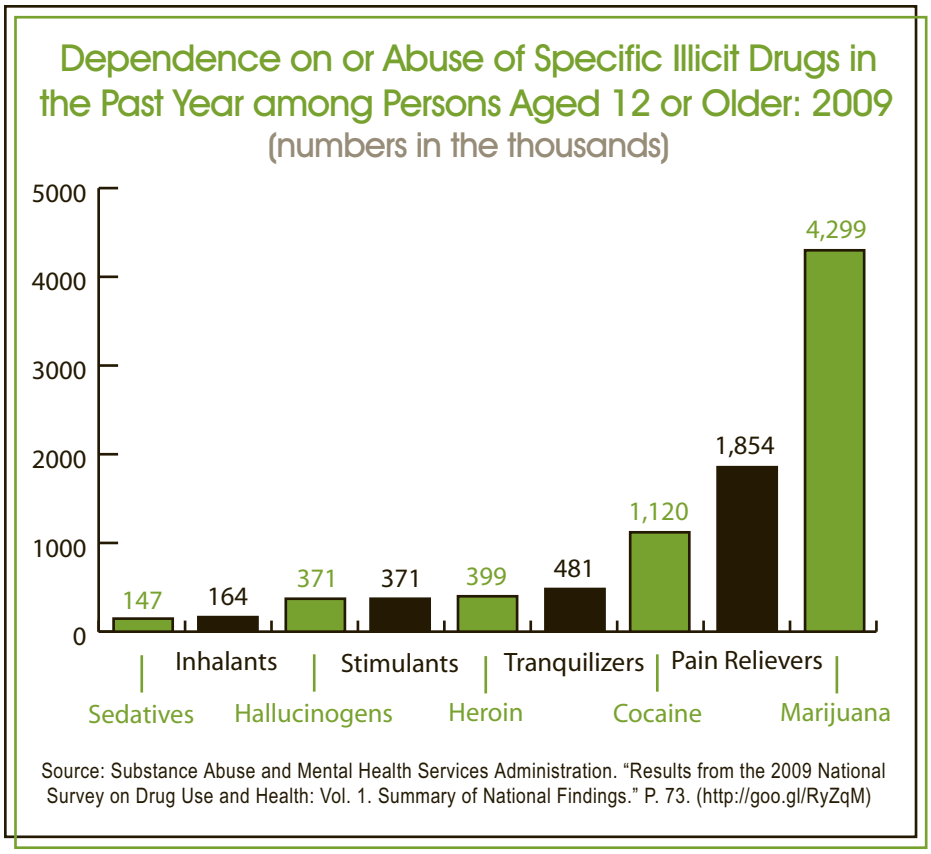
medical condition, the combination increases the person's risk of functional impairment, and decreased length and quality of life.[34] Such co-occurring conditions contribute to the fact that people with serious mental illness die, on average, 25 years earlier than the general population. Their increased morbidity and mortality are largely due to treatable medical conditions, researchers say, caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.[35]

Many of the medications used to treat mental problems can cause weight gain, a risk factor for type 2 diabetes.[36] This could help explain why individuals with schizophrenia have a higher-than-usual rate of diabetes.[37]

On the other hand, many treatments for medical conditions have psychological side effects that can make mental problems worse. Complicating matters, individuals with mental problems may not be able to comply with medical treatment instructions and self-care regimens. For instance, the odds of noncompliance with medical treatment is three times greater for depressed patients compared with non-depressed patients.[38]
Co-occurring conditions also mean higher health care costs. A mental illness, on top of a common chronic physical condition, is associated with a 60 to 75 percent increase in health care costs.[39,40]

IMPLEMENTATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

In contrast to past attempts at health reform, coverage for mental health and substance use conditions was written into the health reform law of 2010 from its earliest drafts. Treatment for mental health and substance abuse conditions was included in the essential benefits package required for health policies to be sold through the new health insurance exchanges be-



ginning in 2014, for example, and, in general, the new law fully incorporated the parity law (see text box).

Many general provisions of the new law reform benefit people with mental health or substance use disorders, such as the elimination of coverage exclusions due to pre-existing conditions and the expansion of Medicaid. The extension of coverage under parents' policies to offspring under the age of 26 will mean that many facing the onset of mental illness will be covered at this critical moment in their lives.

How many of those newly eligible will seek treatment? How will provider agencies integrate with the general healthcare field? Will there be capacity to meet growing demand?

STATE BUDGET PROBLEMS

The recent recession has taken a significant toll on the ability of public mental health and substance abuse treatment systems to maintain the level of services they have traditionally provided.

According to the National Association of State Mental Health Program Directors, average state spending for mental health services shrank 4 percent between 2008 and 2009, and another 5 percent in 2010. Early indications suggest an additional 8 percent cut in 2011.[41]

The National Alliance on Mental Illness (NAMI) reported in March 2011 that states reduced spending on mental health services by a cumulative $1.8 billion between 2008 and early 2011. Typically, states experience budget shortfalls for two years or more after a recession is said to have ended. So most anticipate the present fiscal crisis to continue through FY 2012 or later. "Because virtually all Medicaid-funded mental health services are optional, states projecting another couple years of budget deficits are likely to chop mental health services further," said a NAMI statement.[42]

The cuts are coming at a particularly bad time, with unemployment still high. As noted earlier, a 2009 study showed that being out of work can quadruple a person's likelihood of reporting symptoms consistent with severe mental illness.[43]

TIPS FOR REPORTERS

- Your editor or assignment editor may feel uncomfortable discussing mental illness or may feel that your audience would rather read about something else. You can gently point out that news stories, especially those with "real people," can encourage readers or viewers to get help instead of trying to "tough out" a truly debilitating mental problem.
- Like any field, the mental health and substance abuse communities are home to experts with ideologies or interests that may color their views or the information they provide. Be sure to determine and acknowledge the ties that may influence any expert consulted for a story on mental health or addiction.

- Many people with mental health or substance use disorders are motivated to seek help when they learn that prominent people are working to overcome similar problems. It's worth asking whether the expert you are interviewing has a personal connection with mental illness or substance abuse, such as a family member who needed and sought care.
- Where can you find people with mental illnesses who are willing to be interviewed? Try the national office or your state affiliate of Mental Health America or the National Alliance on Mental Illness. Also check out the Bazelon Center for Mental Health Law (www.bazelon.org) for access to people with serious mental disorders and information on other mental health policy issues.

STORY IDEAS

- How well are mental health and substance abuse services in your area being integrated into general health care?
- Rates of mental illness are higher in some demographic groups than others. What could changes in demographics mean for mental health and substance abuse incidence, treatment and funding?
- As states reduce funding for mental health and substance abuse services in response to large deficits, many losing those services may end up in the criminal justice system. Is this merely cost-shifting from one public sector to another?
- A number of cities, including Los Angeles, Seattle and Miami, have concluded that homeless people who are mentally ill should have secure housing before they can benefit from services for their mental problems.[44] Nationally, the movement is called "Housing First."[45] With some history now behind it, how well is this idea working – for individuals and communities?

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Mental Health and Substance Abuse Parity

One of the biggest U.S. mental health/substance abuse stories in many years occurred in October 2008, when President George W. Bush signed The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 into law.

"Parity" means that when a group health plan covers mental health or substance-abuse conditions, no treatment limitations or financial requirements can be imposed that are stricter than for the medical or surgical benefits provided by the plan.[1] The law corrects practices that had been commonplace, such as putting a limit on the number of times an insured person could see a mental health professional or capping the number of days the person could spend in a mental health or substance abuse facility.

Here are some important facts about the parity provisions:[2]

1. They affect people covered in health plans of 51 or more employees.
2. They don't require that a health plan cover mental health and substance-abuse conditions – but if these services are covered, the provisions apply.
3. If a health plan offers out-of-network benefits for medical or surgical care, it must also offer out-of-network equivalent coverage for mental health and addiction treatment.
4. State parity laws and other consumer protection laws remain in effect unless the state law conflicts with the federal ban on inequitable financial requirements and treatment limitations.
5. Parity provisions apply to people covered by self-insured plans as well as those covered by plans that are subject to state regulation.
6. A health plan can be exempted from the new parity law only if the plan can prove that parity is raising its total plan costs by more than 2 percent in the first year after enactment and 1 percent thereafter. But plans must first implement parity for at least six months.
7. Most health plans change benefits only at the beginning of the calendar year. Thus, most consumers saw the new parity provisions reflected in their health plans after January 1, 2010.

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2 Mental Health America (2008). "Fact Sheet: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008." (www.nmha.org)

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CHAPTER 12

PUBLIC HEALTH

Originally written by Deanna Okrent, Alliance for Health Reform, and updated by Susan Polan, Ph.D., Georges Benjamin, M.D., and colleagues at the American Public Health Association, and by Deanna Okrent.

FAST FACTS

- More than $2.5 trillion was spent nationally on health care in 2009.[1] Of that, only $77 billion or 3 percent was spent on government public health activities.[2]
- An estimated 250,000 more public health workers will be needed by 2020.[3]
- The U.S. public health system is not a single entity. It is a network that encompasses several federal agencies, local, state, and territorial health departments, community-based organizations, health delivery settings and much more.
- There is an epidemic of obesity in the U.S. Two-thirds of adults and nearly one in three children are overweight or obese.[4]
- The effects of climate change can affect human health. Heat waves, drought, flooding and air pollution can cause increases in heat stroke, respiratory illnesses and diseases caused by contaminated food and water supply.[5]
- The health reform law, the Patient Protection and Affordable Care Act of 2010 (also known as ACA), provides important support for public health in the U.S.

See p. 133 for story ideas and p. 134 for a list of experts. For a more detailed version of this chapter and a list of helpful websites, visit www.allhealth.org/sourcebookcontent.asp?CHID=128

BACKGROUND

WHAT IS PUBLIC HEALTH?

"Health care is vital to all of us some of the time, but public health is vital to all of us all of the time."

– C. Everett Koop, former Surgeon General

In late 2009, the public was shocked into the reality of the incidence of foodborne illness because of salmonella detected in spinach. Suddenly, a food that had been considered healthy wasn't, and no one wanted to eat spinach at home, or in restaurants, either cooked or in fresh salads. The Centers for Disease Control and Prevention (CDC) estimates that each year roughly 1 out of 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die from foodborne diseases.[6] Keeping our food supply safe is a major public health concern.

In the previous century, vast improvements in morbidity and mortality were gained through a focus on preventing the spread of communicable diseases. Immunization, disease screening (especially tuberculosis screening), clean water, hand washing, and other sanitation techniques we now take for granted reduced the spread of communicable diseases and were important factors in increasing life expectancy and improving the health of the population.

NEW CHALLENGES

While clean air, water and food are still important concerns, the modern public health agenda focuses on new challenges, the social conditions and systems that affect everyone's healthful living within a given community.. The new epidemics are diabetes, obesity and smoking related illnesses. The leading causes of death are heart disease, cancer and stroke.[7] For people age 1 to 34, motor vehicle-related injuries are the leading cause of death.[8] Childhood obesity rates have tripled over the last thirty years: one third of all children born in 2000 or later will suffer from diabetes at some point in their lives; many others will face chronic obesity-related health problems like heart disease, high blood pressure, cancer, and asthma.[9] In 2008, more than two-thirds of adults were overweight or obese.[10] (See chart, "Adult Obesity in the United States from 1994 through 2008.")

Healthy, Hunger-Free Kids Act

- Sets strict limits for the nutritional content of foods sold in schools. It authorizes the department of Agriculture to update and develop nutrition standards for what can be sold in school vending machines and elsewhere in schools
- Increases the federal reimbursement rate for school lunches in districts that comply with federal nutrition standards.
- Provides an additional 21 million meals annually for at-risk children
- Connects about 115,000 new students to the school meals programs.
- Provides $40 million to help communities establish farm-to-school networks, create school gardens and put more local foods in cafeterias.

Source: The Healthy, Hunger-Free Kids Act of 2010 (www.govtrack.us/congress/bill.xpd?bill=s111-3307)

A law to improve child nutrition and combat obesity was enacted in December 2010. The Healthy, Hunger-Free Kids Act[11] provides $4.5 billion for federal school nutrition programs – a ten-fold increase over the previous reauthorization of this law. (See text box for additional information on the law.)

Public health emphasizes prevention through a whole array of actions which promote healthy lifestyles, including policies and campaigns to improve diets at home, at school and in the workplace; support for tobacco prevention, substance abuse treatment, bike and pedestrian paths to increase physical activity, seat belt use, helmet laws and clean air laws.

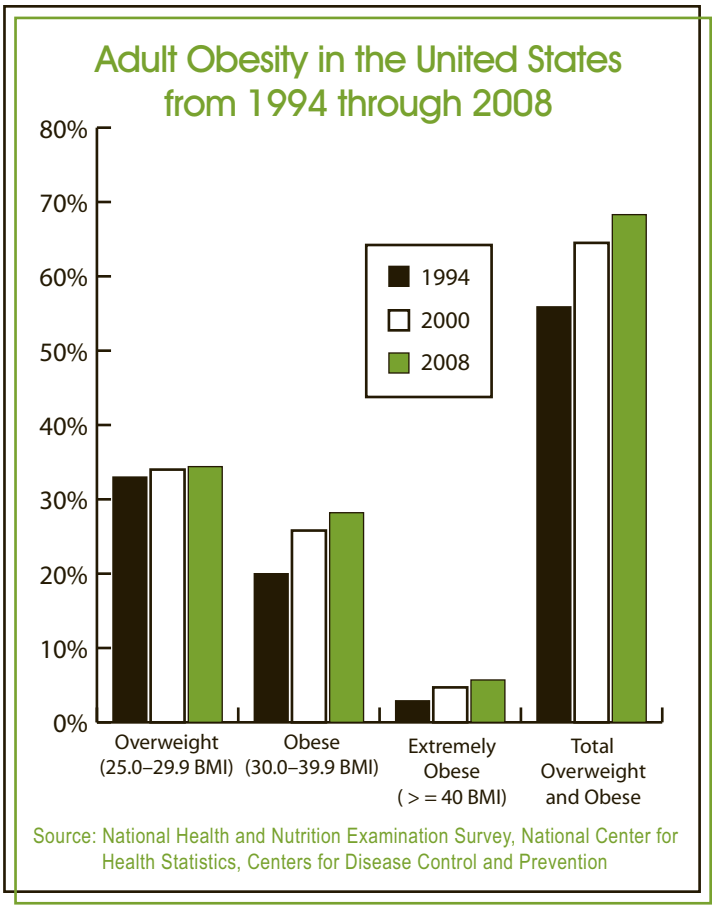
Public health professionals are concerned with emergency preparedness in case of a pandemic, bioterrorism or natural disaster occurrence. They also deal with environmental health and climate change, sprawl, anti-biotic resistance and other threats that were not on the radar screen when public health as a discipline and profession was in the developmental stages.

The U.S. Surgeon General's Office released a report in 2010 entitled *The Surgeon General's Vision for a Healthy and Fit Nation*. The report outlines ways of achieving several important goals:[12]

- Individual healthy choices and healthy home en-

vironments, including making healthier food choices and being more physically active.

- Creating healthy child care settings and healthy schools that include physical activity and good nutrition
- Creating healthy work sites with wellness programs that promote healthy eating in cafeterias and participation in physical activities.
- Mobilizing the medical community to explain the connection between a lifestyle of healthy eating, exercise and good health.
- Improving our communities to increase safe access to supermarkets and outdoor recreational facilities



PUBLIC HEALTH INFRASTRUCTURE

The 2010 health reform law (the Patient Protection and Affordable Care Act of 2010, or ACA) does much to strengthen the public health system, invest in prevention and improve the health of the American people.

A wide array of programs in the law addresses population health, including:[13]

- A National Prevention, Health Promotion and Public Health Council chaired by the Surgeon General.[14]
- A Prevention and Public Health Fund to support core public health functions, community prevention initiatives, increased support for the public health workforce, and public health prevention and research activities
- Community Transformation grants to state and local governmental agencies and community-based organizations.[15]
- Health education[16]
- Workforce development programs and grants.[17]

There are many other important provisions within the law that are not strictly public health but will have positive implications for changing the health. These include enhancing access to preventive services and programs, and promoting primary care and disease management.

HEALTHY PEOPLE 2020

HHS released the Healthy People 2020 objectives in December 2010, building on the successes and challenges realized in the Healthy People 2010 initiative.[18] Healthy People 2010 was a comprehensive, national health promotion and disease prevention agenda developed and promoted by the U.S. Department of Health and Human Services (HHS).[19] It was a roadmap for improving the health of all people in the United States.

It had two primary goals: to increase the quality and years of healthy life, and to eliminate disparities in health status among segments of the population.[20]

The vision for Healthy People 2020 "is a society in which all people live long, healthy lives." It differs from earlier objectives by stressing the underlying environmental and social determinants of health.

Healthy People 2020 strives to:

- Attain high quality, longer lives free of preventable disease, disability, injury and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

PUBLIC HEALTH INFRASTRUCTURE

Public health in the U.S. is not embodied in a single entity. It is a network that encompasses several federal agencies; county, city, state, territorial and tribal health departments; local boards of health; and other public and private entities.

The federal public health component rests primarily in the agencies of HHS.[21] These include the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), Food and Drug Administration (FDA), Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Administration (SAMHSA) and the National Institutes of Health (NIH).

Other agencies involved in health programs at the federal level are the Departments of Defense, Agriculture, Transportation, Housing and Urban Development and Veterans Affairs; the Environmental Protection Agency; and the Indian Health Service, which coordinates tribal health agencies. Other components of the public health infrastructure include public and private laboratories, hospitals and other healthcare providers, and volunteer organizations such as the American Red Cross and others.[22]

Major non-governmental public health associations complete the picture of the public health enterprise and include such groups as the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO) and the National Association of City and County Health Officials (NACCHO). These organizations complement the work of federal, state and local governments.

THE ROLE OF PUBLIC HEALTH

The job of maintaining population health through disease and injury prevention, health promotion and protection is carried out in a number of ways. Public health agencies monitor immunization activities and distribute vaccines through local health departments. The CDC and the FDA conduct environmental surveillance and research and assure the availability of healthy water, air and food. Research institutions and laboratories investigate outbreaks of foodborne and waterborne diseases and educate the populace about avoiding or seeking treatment for such diseases.

CDC allocates close to 75 percent of its funds directly to states and local communities for public health activities.[23]

For example, WISEWOMAN[24], a competitively awarded state-based heart disease and stroke screening and prevention program for uninsured and underinsured low-income women, received $20 million to provide increased resources to the 20 currently funded states in FY 2010.[25]

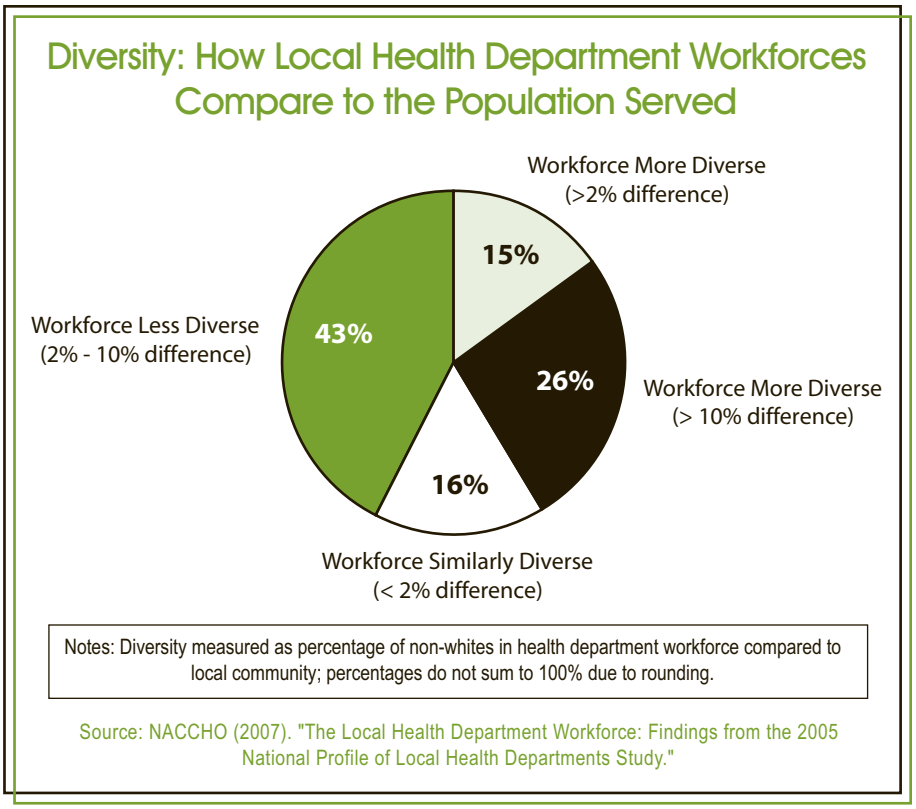
HEALTH THREATS FROM DISASTER, DISEASE AND CLIMATE CHANGE

Some threats to our nation's health come from beyond our geographic boundaries. With travel between countries and continents being easier and faster, so too can be the spread of disease.

H1N1 (originally referred to as "swine flu") was a new influenza virus first detected in March 2009. It was declared a pandemic emergency by the World Health Organization in June 2009 and a national emergency by President Barack Obama in October 2009. The flu afflicted 90 million people in the United States alone. This could have been catastrophic had the virus been more virulent and potentially lethal. Fortunately, it was a mild strain.

Also, with the development and availability of H1N1 flu vaccine and the Public Health Service involvement in vaccinating as many people as possible, the threat, concern and fear have diminished somewhat.[26] However, the question that many public health professionals, political leaders, health care providers and others raise is: Are we prepared for a potential virulent pandemic?

Man-made disasters such as the Deepwater Horizon oil spill may have long term health consequences, and such events require long term follow-up. Immediate health effects in cleanup workers include respiratory symptoms and nausea as well as lower-respiratory-tract problems from inhalation of volatile organic compounds. People living in the surrounding coastal communities could also experience more extreme health consequences, including long-term neurological effects on children and developing fetuses, and hereditary mutations. Health officers in the Gulf states and epidemiologists are now determining the research agenda to study the effects of this disaster.[27]



Climate change, specifically global warming, has been observed by research scientists in the U.S. and around the world. It is believed these changes can affect human health.[28] CDC's Climate-Ready States and Cities Initiative is helping states and cities partner with local and national climate scientists to understand the potential climate changes in their areas, and is assisting states and cities in developing and using models to predict health impacts, to monitor health effects, and to identify the areas most vulnerable to these effects.[29]

PUBLIC HEALTH WORKFORCE

Estimates suggest that 250,000 more public health workers will be needed by 2020, and that 23 percent of the current workforce will be eligible to retire by 2012. Schools of public health estimate that three times the current number of graduates must be trained over the next 12 years in order to keep up with the demand and avert a crisis.[30]

The National Association of City and County Health Officials (NACCHO) in early 2010 completed the third in a series of surveys measuring the impact of the economic recession on local health departments (LHDs). The surveys found that between January 2008 and December 2009, LHDs lost 23,000 jobs to layoffs and attrition, roughly 15 percent of the entire LHD workforce.

In 2009, an additional 25,000 LHD employees were subjected to reduced hours or mandatory furloughs. More than half of LHDs had to make cuts during 2009 to important programs such as population-based primary prevention, maternal and child health, and environmental health. [31]

Factors working against recruitment in this field include: budget constraints; uncompetitive salaries and benefits, especially in local health departments; and lack of enthusiasm for public health as a career choice.[32] Among the public health workers in short supply are public health nurses, epidemiologists, microbiologists, other environmental health scientists, and information technology specialists.[33]

Recently, a helping hand came from the federal government to enhance public health workforce training programs. The U.S. Department of Health and Human Services awarded $16.8 million to support 27 Public Health Training Centers at schools of public health and other public or non-profit institutions across the

country. Most of the funding – $15.4 million – is made available by the Prevention and Public Health Fund included as part of the Affordable Care Act.[34]

Diversity of the public health workforce is also an issue. The workforces of local public health departments are often less diverse than the populations they serve.[35] (See chart, "Diversity: How Local Health Department Workforces Compare to the Population Served.") However, because of the overall concern about the workforce shortage and the already limited pool from which to hire, many communities have found it difficult to increase the diversity of their public health workforce.

LIKELY POLICY DEBATES

POPULATION HEALTH

Population health plays an important role in the health of the nation. Yet its importance is sometimes overlooked in debates on health care reform issues. It is not well understood that public health is about avoiding illness and thus avoiding unnecessary use of the health care delivery system.

Many public health concerns, though focused on populations, not individuals, cannot be separated from health care delivery. For example, chronic disease prevention – a focus of health promotion public awareness campaigns – is being much discussed in health care delivery circles.

FINANCING PUBLIC HEALTH

Though public health services are considered the first line of defense against disaster and disease, government public health expenditures amount to only 3 percent of national health care expenditures.[36] Of the $2.5 trillion in national health expenditures in 2009, just $77 billion was spent on government public health activities.[37]

In the wake of the recent economic downturn, states have cut hundreds of millions of dollars from public health programs, leaving many communities around the country struggling to deliver basic public health services. [38]

In a climate of health reform, some advocates assert that more dollars for prevention would buy better value and save money in the long run on health care delivery.[39]

ACCOUNTABILITY AND QUALITY

Several organizations founded in the last several years address the twin issues of accountability and quality. The National Board of Public Health Examiners offers public health student graduates the opportunity to prove they have met minimum standards and can become certified public health professionals. The National Public Health Accreditation Board focuses on the public health system and is charged with improving the quality and performance of state, local, tribal and territorial health departments.

The Task Force on Community Preventive Services evaluates and then helps to prioritize in its Community Guide population-based programs and policies to improve health and prevent disease in communities.[40] The U.S. Preventive Services Task Force is an independent task force that reviews the effectiveness and makes recommendations for clinical preventive services.

Do these entities begin to offer a more comprehensive approach to a public health system that too often offers inconsistent quality and accountability depending on where it is located?

CLIMATE CHANGE

Climate change can have dramatic public health consequences – increasing the likelihood of heat waves, drought and flooding, reducing potable water supplies, displacing populations and spreading infectious diseases.[41] Though populations are affected, individuals become ill and interact with their health care providers, putting stress on the health care system. A public policy debate on climate change or global warming might be centered on energy issues but will also have a public health component. Is global warming the new public health challenge?

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Many different policies and programs have implications for the public's health, but are not considered public health. Examples are community development with regard to safe housing, transportation spending

and school nutrition and physical education programs that fall under the education budget. What role should the public health sector have in the development and implementation of such policies? Should health concerns be considered when establishing new policies outside the traditional realm of public health? What are the obstacles and challenges?

TIPS FOR REPORTERS

- Keep in mind that there is no one source for information about public health agencies. The U.S. Department of Health and Human Services (HHS) is the lead agency. But information about this complex network requires digging deeper. In addition to HHS components such as CDC, NIH, FDA and HRSA, other federal agencies and departments such as FEMA and Homeland Security all play a role.
- Be aware that on the local level, most public health functions are carried out through local health departments. Their budgets depend on federal, state and local budget allocations. They likely will continue to make tough budgetary choices in the next few years.
- The private sector plays a role in funding public health and delivering public health messages. Its role may be even more critical in the current economic climate.
- It's hard to separate public health issues and concerns from those of the health care delivery system. Keep in mind that an important role of public health is to prevent illness and thus avoid unnecessary use of the health care delivery system.

STORY IDEAS

- Acts of terrorism threaten our health security. Could our infrastructure, including hospitals, laboratories, information systems and public health workforce handle the expanded need in the event of a major terrorist attack? Would our surveillance systems provide sufficient warning to protect people from exposure and prevent the spread of disease? Would we have sufficient surge capacity to handle the results of bioterrorism? One year after the H1N1 national emergency, these questions are still being discussed, and real world lessons learned being evaluated. Are public health officials in your community working with hospitals and other health officials in preparation for potential catastrophic health needs? Is there an emergency preparedness plan in your community?
- In a time of tight budgets, how are public health departments in your area faring? What programs are suffering – vaccination programs, health awareness campaigns, smoking cessation programs? What is the role of private sector contributions? Are these contributions increasing or decreasing?
- Were businesses and citizens in your area affected by the spinach contamination in the fall of 2009?[42] If so, how many and how seriously? Have there been other contaminated food products in your area recently and who may have been affected? Are we dealing with such threats effectively?
- How do your local and state public health officials feel about climate change as a public health threat? What are the health impacts of climate change in your region? What role are public health agencies and programs playing in reducing the threat posed by high energy consumption and climate change?
- Are health departments involved in land use and transportation decisions in your community? In bringing supermarkets and outdoor recreation facilities into neighborhoods?
- Did schools of public health in your area get workforce dollars? If so what are the plans for their use? Which programs and professions will benefit?
- How can new graduates be inspired to enter the public health workforce? How can students entering college be encouraged to study the public health sciences such as epidemiology, microbiology, biostatistics, etc? What incentives have worked in your community to motivate graduates to pursue these careers? What are the obstacles that graduates are experiencing to entering the public health workforce?

- What public health programs in your state receive public health funding? What are their achievements? Are these programs being cut, maintained or expanded?

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APPENDIX

POLLS ON HEALTH CARE ISSUES

Health care has consistently rated as one of the most important issues on the minds of Americans. The list below includes organizations that track public opinion about health care as an issue, and about specific topics within the health care universe.

American Association for Public Opinion Research
www.aapor.org

AAPOR is an association of individuals who share an interest in public opinion and survey research. The group publishes the Public Opinion Quarterly journal. The "Press Room" section includes tips on understanding and writing about poll results.

American National Election Studies
www.electionstudies.org

American National Election Studies produces data to help explain why Americans vote as they do on election day. A collaboration of Stanford University and the University of Michigan.

Annenberg Public Policy Center
www.annenbergpublicpolicycenter.org

The center, part of the University of Pennsylvania, features Peter Hart's Voices of the Voters among its special projects. Not a poll, Voices of the Voters is a series of focus groups conducted since 2004 to gain insights into attitudes about presidential candidates and issues. As the 2012 campaign heats up, these insights should be useful to reporters writing about health reform as a campaign issue.

The Commonwealth Fund, Surveys & Data
www.commonwealthfund.org/Surveys.aspx

The Commonwealth Fund tracks trends in health coverage, access and quality, and general policy/practice issues in the U.S. and internationally. The fund and *Modern Healthcare* magazine sponsor the Health Care Opinion Leaders Survey, which regularly samples more than 1,300 opinion leaders in health policy, along with innovators in health care delivery and finance.

Employee Benefit Research Institute
www.ebri.org/surveys/hcs

Since 1998, the EBRI Health Confidence Survey has tracked a broad spectrum of health care issues, including Americans' satisfaction with health care, their confidence in the health care system of today, the future of the health care system and the Medicare program, and their attitudes toward health care reform.

Gallup Organization
www.gallup.com/consulting/healthcare/101797/Homepage.aspx

The Gallup Organization has studied human nature and behavior for more than 70 years. Site links to

polls of interest. Featured on the website is the Gallup – Healthways Well-Being Index®, "the first-ever daily assessment of U.S. residents' health and well-being."

Harris Interactive
www.harrisinteractive.com/NewsRoom/HarrisPolls.aspx

Harris Interactive is a worldwide market research and consulting firm best known for The Harris Poll and for pioneering an internet polling method that produces reliable results. Polls include subjects such as "One Nation Divided Over Health-Care Reform" (Dec. 6, 2010).

Harvard Opinion Research Program
www.hsph.harvard.edu/horp

The Harvard Research Program has played a key role in 100+ public opinion surveys on health and social policy in the U.S. and 15 other countries. The program specializes in assessing people's attitudes in relationship to their values, knowledge and experiences. Researchers have published 120+ articles in four major areas, such as election studies.

Kaiser Family Foundation Polls
www.kff.org/kaiserpolls/index2.cfm

KFF undertakes original research on the public's attitudes towards health and social policy issues. Working independently – or in partnership with major national media organizations and academic partners – the foundation examines Americans' knowledge and beliefs on major issues and challenges in order to amplify the public's voice in national debates.

Kaiser Health Tracking Poll
www.kff.org/kaiserpolls/trackingpoll.cfm

KFF has conducted polls twice a month for 12 years tracking the public's experiences in the health care system, their ranking of health as a policy priority, and their views on health care reform.

Kaiser Health Poll Search
www.kff.org/kaiserpolls/healthpoll.cfm

Health Poll Search is a comprehensive, searchable archive of health-related public opinion questions that allows users to know what Americans think and have thought about health issues over time. Health Poll Search is the result of a partnership between the Kaiser Family Foundation and The Roper Center for Public Opinion Research at the University of Connecticut. The Roper Center houses an archive of more than 500,000 public opinion questions dating back to 1935.

National Council on Public Polls
http://ncpp.org/

The National Council on Public Polls (NCPP) is an association of polling organizations established in 1969. Its mission is to set the highest professional standards for public opinion pollsters, and to advance the understanding, among politicians, the media and general public, of how polls are conducted and how to interpret poll results. Since its inception, NCPP has sponsored seminars, workshops and press conferences in Washington and New York to promote better understanding and reporting of public opinion polls. For more information, contact: info@ncpp.org.

Pew Research Center for the People and the Press
http://people-press.org/dataarchive

The Pew Center is an independent opinion research group that studies attitudes toward the press, politics and public policy issues. They are best known for regular national surveys that measure public attentiveness to major news stories, and for their polling that charts trends in values and fundamental political and social attitudes. See "Data Sets" and "FYI Other Polls."

The Polling Report
www.pollingreport.com

PollingReport.com is a compilation of polls from organizations such as the Associated Press, CNN, USA Today and Gallup, among others. The website is updated whenever new polls are released. Data are from national probability-sample surveys of the American public. Additional data – including state-by-state presidential, congressional, and gubernatorial polls – plus analyses by leading pollsters, are available to subscribers (fee required). To see how health care ranks among other national priorities, click on "National Priorities" under the "State of the Union" button.

The Roper Center for Public Opinion Research
www.ropercenter.uconn.edu

Founded in 1947, the Roper Center for Public Opinion Research at the University of Connecticut bills itself as the leading educational facility in the field of public opinion. The center promotes the intelligent, responsible and imaginative use of public opinion in addressing the problems faced by Americans and citizens of other nations. Check what's new under the "Quick Links" button in the left column of the home page.

Zogby International
www.zogby.com

Zogby International has been tracking public opinion since 1984. Enter a term in the search box to find Zogby polls related to a number of health topics.

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APPENDIX

COVERING HEALTH ISSUES FOR TV AND RADIO

Originally written by Deborah Potter, president and executive director of NewsLab (www.newslab.org), former network correspondent for CBS and CNN.

The vast majority of health stories on local television are medical reports about diseases, lifestyles, experimental tests and treatments. Many of these stories aren't even local, although they may be "fronted" by a station's reporter or anchor. Hundreds of newsrooms depend on feed services like Ivanhoe Broadcast News and Medstar Television to provide their daily health reports.

Let's face it: issues like insurance coverage, prescription drug costs and access to health care may be important, but they aren't easy to cover. That's why we are offering the following tips to help you tackle these stories and make them both interesting and understandable to your audience. While these tips are written with television reporters in mind, many of them apply just as well to radio reporters.

PEOPLE

FIND A CENTRAL CHARACTER

The best stories are about people; they don't just use people as an opening and/or closing anecdote. They have what one news manager calls the "RH factor" - real humans. "The art of getting public policy on TV," says Susan Dentzer, formerly of PBS, "is to go out and find the person whose plight encapsulates at least some of the issues." However, finding people who are willing to go on camera is often difficult. Some reporters have had success in finding participants by working through special interest groups.

CHOOSE AN EXPERT WHO CAN SPEAK SIMPLY

Find an expert who can explain complex issues simply. One way to do this is to ask potential experts if they are comfortable being called by their first name. A PBS producer uses this as a simple litmus test for finding experts who are willing to forego technical language. (You can to learn more about the Alliance for Health Reform's Find-an-Expert Service for reporters at www.allhealth.org/reporter_enroll.asp.)

USE SIMPLE LANGUAGE YOURSELF

Experts often speak in their own jargon, which is virtually unintelligible to the general public. Asking better questions can get you better sound bites. Use simple language in your questions, so people will respond similarly. For example, don't ask about mor-

bidity rates; ask how many people are sick. Dentzer, now editor-in-chief of *Health Affairs* journal, told sources they should treat her like a very intelligent 12-year-old. "Because I'm intelligent, they won't talk down to me," she says, "but if I'm 12, they know they need to explain things."

EXPERTS MAY NOT BE REQUIRED

Not every story needs to include a sound bite from a traditional "expert." While you'll probably consult experts no matter what, you don't have to use them on camera. Instead, you can summarize their views in simple language and in less time. Remember that people are experts about their own lives, so let them speak about what they know. In stories about children's health, let the viewer hear from children. But be careful to verify all information. Dentzer has found that people are often confused about their specific medical condition, so she asked for permission to confirm information with their doctors and to see supporting documents.

VISUALS

SHOOT ACTIVE INTERVIEWS

Talk to people while they are doing something connected to the story, and shoot b-roll at the same time as the interview. If you're asking about prescription drug costs, talk while the person sorts through their medications; if you're discussing insurance coverage, talk while looking at their hospital bill. Before setting up an interview with an expert, explain your need for video but be clear that you are not asking for anything to be arranged for your convenience. Sometimes experts are too willing to stage activities that they think will be "good TV." In addition, good communication between reporter and photographer is essential to making sure you have the sound bites you need. The extra effort required will pay off in time saved both during the shoot and in the editing room.

AVOID "WALLPAPER" VIDEO

Video should help viewers understand the story, and generic or file tape does little to achieve that goal. In fact, research suggests that when viewers see familiar file tape, they conclude that there is nothing new about the story they are watching and are likely to tune it out. Shoot or obtain fresh and specific video for each story, if at all possible, and write copy that helps viewers understand what they're looking at and why.

ASK FOR HOME VIDEO AND STILL PHOTOS

Home video and stills can help to put a human face on a story and offer context for stories in which a main character has undergone dramatic change. For example, a story about hospital errors could use home video to show how a patient appeared before his or her hospitalization.

BE CAREFUL WITH VIDEO NEWS RELEASES

VNRs can provide you with video you couldn't get any other way. Sometimes the pictures are worth using, but you should ask a few questions first. Would this even be a story if you didn't have the video? Were you working on it already or did it just land on your desk? Whose agenda would you be promoting if you used the video? If you do use it, identify the source of the video, ideally both in track and in a chyron that stays up for the duration. Be extremely cautious about using sound from anyone other than a clearly identified official. How can you be sure that someone identified as a patient really is?

LOOK FOR OTHER VIDEO SOURCES.

JAMA, *The Journal of the American Medical Association*, offers the JAMA Report, a downloadable weekly video (and audio) feed related to its top story (www.thejamareport.com). Many big medical groups, like the American Heart Association, also have sizeable tape libraries. Researchers also shoot video that can be used to illustrate results. Finally, consider using historic footage, which can show how things used to be, compared to the way they are today.

GRAPHICS

CONSIDER USING ANIMATED GRAPHICS

Animation can help clarify how a complex process works. Research shows that viewers pay attention to animations and are more likely to understand a difficult story that uses animation than one using static, full-screen graphics. Consultant Tom Dolan con-

cludes from watching focus groups that "they will not zap your channel" when animations are in use.

CONSTRUCT GRAPHICS THAT SHOW RATHER THAN TELL

Graphics that show how things relate to each other work better than plain words and numbers. If one hospital charges twice as much as another for the same procedure, you might use a bar graph to clearly show the relationship between the two. If a senior citizen spends close to half her income on prescription drugs, you could use a pill-shaped pie chart to illustrate the ratio.

BRING DOCUMENT-HEAVY STORIES TO LIFE

Use specific techniques to enliven the actual documents themselves, instead of creating a stand-alone graphic. Former television investigative reporter Valeri Williams says that while it's easier for graphic artists to recreate the information in a document, she insists on showing the actual document for two reasons. "It adds legitimacy in the eyes of the viewer, and it's one more layer of protection if I end up in court." Use a highlighter or selective lighting to make the important words jump off the page. When shuffling papers, capture the natural sound and use it. Or have someone directly involved in the story read the document, like a denial of benefits letter.

STORYTELLING

USE ANALOGY OR METAPHOR

Look for a way to explain the issue by comparing it to something else people might already have experienced. Ask the people who know the issue best to help you find an analogy or metaphor. What else is this problem like? Could you compare an insurance company's decision to drop coverage for certain people to a game of "knock-out" basketball? Finding an analogy can lead you to pictures that will illustrate the story.

USE "SHOW AND TELL" STAND-UPS

A visual analogy performed by a reporter can help explain complicated issues. Consider using props that can turn a concept into something concrete. A managed care system that rejects patients based on preexisting conditions could be illustrated using a coin-sorting machine.

VARY YOUR FORMAT

Not all health stories need to be packages. Consider on-set explainers or natural sound stories to share an experience or situation with the viewer.

USE THE WEB

Time constraints often limit the amount of detail broadcast stories can include, but the Web has unlimited space where you can post additional information. Put databases, survey results and other statistics on your Internet site and make them searchable, so people can easily find and compare costs and services.

PLANNING

WORK AHEAD

It takes time and effort to arrange a shoot in a hospital, doctor's office, or other locations where patient privacy is an issue. Jaine Andrews, managing editor and former health reporter at KELO-TV in Sioux Falls, SD, says she began planning a series on heart attacks three months in advance of the target airdate. This gave her time to meet with the hospital's marketing department, cardiac physicians, and ER staff, setting ground rules for the shoot.

SHARE YOUR PLAN

Involve photojournalists and producers early on in discussions about what the story will show and why it matters. Let the people you will be featuring know what you're doing as well. Jaine Andrews posted notices throughout the hospital explaining why cameras were present and stating that anyone could request that they not be included in the video.

SELLING

EXPLAIN THE SIGNIFICANCE

Managers who are used to thinking of health stories as reports on medical breakthroughs need to know why a policy issue deserves airtime. Make a good pitch to get these stories on. Point out that stories about health care costs and coverage are of almost universal interest, unlike "disease-of-the-day" reports. They also affect people's pocketbooks. And because you will be

presenting the story in an interesting way, it won't fit anyone's preconceived notion of a dull policy story.

FIND THE LOCAL ANGLE

Health policy stories affect people in your community. If you look, you can find local groups that are actively involved in just about every aspect of health policy.

HIGHLIGHT VIEWER INTEREST

Collect and use survey results that make clear how much viewers care about health care costs and coverage. A NewsLab survey of self-described light TV viewers asked what kinds of stories might make them watch more often. Health reports ranked just behind education as the topic of greatest interest, but respondents defined the health beat more broadly than many stations do. They wanted to know about good and bad doctors, health insurance and nursing homes, not just about the latest diet tip or experimental treatment.

POINT TO RATINGS SUCCESSES

Valeri Williams, the former investigative reporter who has probed many medical issues, says these stories can pay tremendous dividends in ratings. "I would challenge any news director in second or third place [in the ratings] to let a reporter work on a health investigation for a few weeks and see what difference those nights, properly promoted, make in the book." Williams has investigated government oversight of vaccines and the performance record of HMOs, topics that drew thousands of e-mails and phone calls from viewers.

STORY EXAMPLES

(We apologize in advance if any links shown are inactive by the time you try to watch or listen to these stories. The online version of this chapter will have examples with active links - www.allhealth.org/sourcebookcontent.asp?CHID=130. If you would like to suggest examples for the online version, please email them to info@allhealth.org.)

Disparities in Care
"Twice as Deadly"
WBEZ - Chicago, http://goo.gl/Xj2V2

Several years ago, doctors and scientists faced a troubling fact: although black women in Chicago are less likely to get breast cancer than white women, they are much more likely to die from it. New research is starting to unravel the reasons why, and it's finding that the causes are woven deeply into the social fabric of the city. The program explores those findings in this special, and show that they are linked to segregation, cultural factors and policy.

End-of-Life Care
"Quality of Death"
WBUR – Boston, http://goo.gl/PaJSN

In this radio documentary about end-of-life care in America, special correspondent Rachel Gotbaum investigates what prevents many patients from having a dignified death. From well-intentioned but maybe unwarranted medical interventions, to the pressure from family members, to the difficult decisions doctors have to make when treating elderly patients, this program delves into the challenges in America of proper end of life planning and a "respectful death."

Health Reform
"Sick Around America"
Frontline, http://goo.gl/VANgv

Frontline traveled the country studying America's broken health care system and exploring the need for a fundamental overhaul. Features the stories of individuals driven into bankruptcy by health care bills, people unable to afford the treatment they need and others losing insurance coverage just when they need it the most.

Health Reform
"Health Care Anniversary: Advocates Enroll LA Families"
NBC Los Angeles, http://goo.gl/04qaX

This story, on the one-year anniversary of the health reform law, looks at how the law will benefit Latino families in Los Angeles, and is already helping some.

Health Workforce Shortages
"Crisis in Caring: California's School Nursing Shortage"
KVIE – Sacramento, http://goo.gl/glz8X

This program focuses on the critical shortage of

school nurses in Northern California and its impact on students, teachers, parents and whole communities.

Medicaid Cuts

"With Budgets Tight, States Look to Medicaid Cuts"
PBS NewsHour, http://goo.gl/Mo8ST

Health correspondent Betty Ann Bowser explores what states are doing to reduce Medicaid expenses, and how citizens are reacting.

Mental Illness

"My Mother's Garden"
MSNBC, http://goo.gl/VtyLZ

"My Mother's Garden" is the story of 61-year-old Eugenia Lester, whose hoarding disorder has taken a life-threatening turn. Lester lives among piles of debris and rotting garbage that have literally pushed her out of her house and into her garden. Upon learning that Eugenia is in danger of losing her home for violating city health codes, her children step in.

Rationing

"Rationing Health: Who lives? Who decides?"

PRI's The World, http://rationinghealth.org/

Some experts say to control medical costs, America must ration health care. Others argue that care is already rationed in the U.S., often in hidden ways. It's a highly charged issue. Even the term "rationing" is subject to dispute. PRI's The World takes a global look at the topic with four perspectives from four countries.

B

GLOSSARY

ACRONYMS

The following list is a guide to some of the more common acronyms and abbreviations for health care agencies, terms and programs. A number of these acronyms and abbreviations are defined in the glossary.

ACF	Administration for Children and Families
ACA	Affordable Care Act (Patient Protection and Affordable Care Act)
ACO	Accountable Care Organization
ADL	Activities of Daily Living
AF4Q	Aligning Forces for Quality
AHRQ	Agency for Health care Research and Quality
ALF	Assisted Living Facility
ASO	Administrative Services Only Agreement
CAH	Critical Access Hospital
CBO	Congressional Budget Office
CCIIO	Center for Consumer Information and Insurance Oversight
CCRC	Continuing Care Retirement Community
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	Children's Health Insurance Program (formerly State Children's Health Insurance Program)
CHIPRA	Children's Health Insurance Program Reauthorization Act
CLASS Act	Community Living Assistance Services and Support Act
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPI	Consumer Price Index
CRS	Congressional Research Service
DME	Durable Medical Equipment; Direct Medical Education Payment
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis-Related Group
DSH	Disproportionate Share Hospital Adjustment
EHR	Electronic Health Record
EMR	Electronic Medical Record
EOL	End-of-life
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services

ERISA	Employee Retirement Income Security Act
ESI	Employer -Sponsored Insurance
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level or Line
FQHC	Federally Qualified Health Center
FSA	Flexible spending account/arrangement
GAO	Government Accountability Office
GME	Graduate Medical Education Payment
HCBS	Home and Community-Based Services
HCERA	Health Care and Education Reconciliation Act of 2010
HCFA	Health Care Financing Administration
HCTC	Health Coverage Tax Credits
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HHS	Department of Health and Human Services
HI	Medicare Hospital Insurance Trust Fund (also known as Part A)
HIT	Health Information Technology
HIFA	Health Insurance Flexibility and Accountability Demonstration Initiative
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOA	Health Opportunity Account
HPSA	Health Professional Shortage Area
HRA	Health Reimbursement Arrangement/Account
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
IADL	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IGT	Intergovernmental Transfer
IHS	Indian Health Service
IME	Indirect Medical Education Adjustment
IOM	Institute of Medicine
IPA	Independent Practice Association
JCAHO	former abbreviation for The Joint Commission
LTC	Long-Term Care
MA-PD	Medicare Advantage Prescription Drug
MCH	Maternal and Child Health
MCO	Managed Care Organization
MedPAC	Medicare Payment Advisory Commission
MEWA	Multiple Employer Welfare Association
MHPA	Mental Health Parity Act
MLR	Medical Loss Ratio
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MRDD	Mental Retardation and/or Developmental Disability
MSA	Medical Savings Account

MSP	Medicare Savings Program
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NDEP	National Diabetes Education Program
NIH	National Institutes of Health
NP/RNP	Nurse Practitioner (Registered)
OCIIO	Office of Consumer Information and Insurance Oversight (now CCIIO Center for Consumer Information and Insurance Oversight)
ONC	Office of the National Coordinator for Health Information Technology
OMB	Office of Management and Budget
P4P	Pay for Performance
PACE	Program of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager
PCCM/PCI/PCC	Primary Care Case Management, Initiative, or Clinician
PCMH	Patient-Centered Medical Home
PCORI	Patient- Centered Outcomes Research Institute
PDP	Prescription Drug Program
PHS	U.S. Public Health Service
POS	Point-of-Service Plan
PPACA	Patient Protection and Affordable Care Act (also referred to as ACA)
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSO	Patient Safety Organization
QALY	Quality-Adjusted Life Years
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
RVS	Relative Value Scale
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHP	Small Business Health Plan
SCHIP	State Children's Health Insurance Program (now CHIP—Children's Health Insurance Program)
SGR	Sustainable Growth Rate
SHIP	State Health Insurance Assistance Program
SLMB	Specified Low-Income Medicare Beneficiary
SMI	Medicare Supplementary Medical Insurance (also known as Part B)
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TMA	Transitional Medical Assistance
TPA	Third Party Administrator
UPL	Upper Payment Limit
UR	Utilization Review

GLOSSARY TERMS

ACTIVITIES OF DAILY LIVING (ADL) – An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating and transferring (moving from a bed to a chair, for example). Used to determine need for long-term care and eligibility for payments for care by insurers. (Contrast with Instrumental Activities of Daily Living)

ACUTE CARE – Medical services provided to treat an illness or injury, usually for a short time. Contrast with Chronic Care.

ADMINISTRATIVE SERVICES ONLY (ASO) AGREEMENT – A contract typically between an insurance company and a self-funded plan or group of providers in which the insurance or management company performs only administrative services (billing, plan design, claim processing, marketing, for example) and does not assume any risk. Also see Self-Insurance.

ADVANCEABLE TAX CREDIT – A subsidy to help pay for health insurance that is available when the insurance premium is due, without having to wait until a year-end tax return is filed. Also see Tax Credit.

ADVERSE SELECTION – When a disproportionately high number of individuals in poorer than average health enroll in a health plan.

AGENCY FOR HEALTH CARE RESEARCH AND QUALITY (AHRQ) – The lead federal agency for research on health care quality, costs, outcomes and patient safety.

ANNUAL BENEFIT LIMIT – Limit on the amount of claims an insurer will pay in a given year for an individual.

AFFORDABLE CARE ACT (A SHORTENING OF PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010) – Law enacted in March 2010, phasing in major expansions in insurance coverage, changes in insurance rules and delivery system changes over the next several years.

ALIGNING FORCES FOR QUALITY (AF4Q) – A national program of the Robert Wood Johnson Foundation designed to help communities across the country improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression and heart disease. (See Chapter 3 – Quality)

AMBULATORY CARE – Medical service provided on an outpatient basis (no overnight hospital stay). Services may include diagnosis, treatment, surgery and rehabilitation.

ANY WILLING PROVIDER – A requirement - typically a state law - that a managed care organization must accept any properly licensed provider willing to meet the terms of a plan's contract, whether the organization wants or needs that provider. Often described by managed care groups as "anti-managed care" legislation.

APPEAL – A request for review of a denial of coverage of a particular medical service or inadequate payment for services already received. Medicare beneficiaries have the right to appeal in either of these circumstances, whether they are enrolled in traditional Medicare or in a Medicare Advantage plan. Under the ACA, all consumers will have the right to appeal decisions, including coverage denials and rescissions, made by their health plans first through the plan's internal process and then to an outside, independent decision-maker. Also see Grievance.

ASSISTED LIVING FACILITY (ALF) – A group residence offering 24-hour assistance to those who may need some help with activities of daily living, but who do not need the level of medical and nursing care offered by skilled nursing facilities.

B

BALANCE BILLING – A provider's bill to a covered person for charges above the amount paid by the health plan or insurer.

BASIC HEALTH PLAN (BHP) – Beginning in 2014, states will have the option of creating a basic health plan to provide coverage to individuals with incomes between 133 and 200 percent of poverty, in lieu of having these individuals get coverage through the state's health insurance exchange and receive premium subsidies. The plan would exist outside of the health insurance exchange and include the essential health benefits as defined under the ACA. Cost-sharing under this plan would also be limited. If states choose to offer this plan, the federal government will provide states 95 percent of what it would have paid to subsidize these enrollees in the health insurance exchange.

BEHAVIORAL HEALTH – Medical services encompassing mental health care and substance abuse treatment.

BENCHMARKS – Goals set as a way for hospitals and doctors to analyze quality data, both internally, and against data from other hospitals and doctors to identify best practices of care and improve quality.

BEST PRACTICES – The most up-to-date patient care methods, which result in the best patient outcomes and minimize patient risk of death or complications.

BIOSURVEILLANCE – Automated monitoring of health data sources of potential value in identifying trends that may indicate an emerging epidemic, whether naturally occurring or the result of bioterrorism.

BLOCK GRANT – A lump sum of money given to a state or local government to be spent for certain purposes. Normally, it is based on a formula, the objectives are broadly defined and the grant's source places relatively few limits on the money's use.

BUNDLING – See Payment Bundling

C

CAFETERIA PLAN (SECTION 125 PLAN) – A cafeteria plan provides participants an opportunity to receive certain benefits, such as reimbursement for some out-of-pocket medical expenses, on a pretax basis. It is a separate written plan maintained by an employer for employees that meets the specific requirements of Section 125 of the Internal Revenue Code.

CAHPS (H-CAHPS OR CAHPS HOSPITAL SURVEY) – The Consumer Assessment of Health care Providers and Systems is a national, standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care, thus enabling valid comparisons to be made across all hospitals. CAHPS was developed by the Agency for Health care Research and Quality in partnership with numerous private organizations (www.cahps.ahrq.gov).

CAP – See Out-of-Pocket Cap

CAPITATION – Method of payment for health services in which a health care provider is paid a fixed amount for each person on the provider's patient roster, regardless of the actual number or nature of services provided to each person.

CARRIER – An entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

CARVE-OUTS – A payer strategy in which a health maintenance organization (HMO) or insurance company isolates ("carves out") a benefit and hires another organization to provide this service. Common carve-outs include behavioral health and prescription drugs. The technique is intended to allow the insurer to better control its costs.

CASE MANAGEMENT – A process where a health plan identifies covered persons with specific health care needs, then devises and carries out for them a plan to achieve the best patient outcome in the most cost-effective manner.

CASE MIX – The mix of patients treated within a particular institutional setting such as a hospital or under a particular health plan. Case mix may be measured by the severity of patients' illnesses or the prospective use of care resources.

CASE MIX ADJUSTMENT – Change in payment to a health plan or provider to avoid overpaying or underpaying where health status or likely use of services varies from average.

CASH AND COUNSELING – A Medicaid program that allows certain Medicaid beneficiaries, frail elders and adults with disabilities to purchase their own personal care and related services. Medicaid provides a monthly allowance, the amount of which is determined after assessing the beneficiary's need for community-based long-term care services. As of October 2011, Cash and Counseling is to be replaced by the Community First Choice Option, a provision of the ACA that will be available in all states. For more information, see Chapter 9, Long-Term Care.

CATASTROPHIC HEALTH INSURANCE – Health insurance which provides protection against the high cost of treating severe or lengthy illnesses. Such policies cover all or most of medical expenses above a relatively high specified amount.

CATASTROPHIC ILLNESS – A very serious and costly condition that could be life threatening or cause life-long disability and which often involves severe financial hardship.

CATEGORICAL ELIGIBILITY – Medicaid's eligibility pathway for individuals who can be covered. The program's 25+ categories have been organized into five broad groups - children, pregnant women, adults in families with dependent children, individuals with disabilities and the elderly. The ACA expands Medicaid eligibility to all individuals under age 65 with incomes up to 133 percent of the federal poverty level and who are not eligible for Medicare, effective January 1, 2014. For more information, see Chapter 8, Medicaid.

CENTERS OF EXCELLENCE – Health care facilities selected to deliver specific services, often exclusively, based on criteria such as experience, outcomes, efficiency and effectiveness.

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT. – Created by the ACA to ensure compliance with the new insurance market rules, this agency of the U.S. Dept. of Health and Human Services oversees the new medical loss ratio rules and assists states in reviewing insurance rates. In addition, it oversees the state-based insurance exchanges, the temporary high-risk pool program and the early retiree reinsurance program. It also compiles and maintains data for an internet portal providing information on insurance options. Formally the Office of Consumer Information and Insurance Oversight.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
(FORMERLY: HEALTH CARE FINANCING ADMINISTRATION, HCFA) – The federal agency administering the Medicare, Medicaid and Children's Health Insurance programs. CMS seeks to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.

CERTIFICATE OF NEED – The requirement that a health care institution obtain permission from an oversight agency before making major changes to its facilities or facility-based services, or before building new facilities.

CHERRY PICKING – The practice of insurance companies taking only those businesses or individuals that are good health risks, and avoiding businesses or people that have higher health risks. Also called "skimming."

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) – A program enacted by Congress in 1997 that provides federal matching funds for states to spend on health coverage for uninsured kids. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private coverage. Congress initially authorized CHIP for a 10-year period that expired at the end of September 2007. CHIP was reauthorized and enlarged early in 2009. The bill increases CHIP funding by about $32 billion through 2013 to cover an additional 4 million children. The ACA requires states to maintain existing income eligibility levels for children in CHIP (and Medicaid) until 2019 and extends funding for CHIP through 2015. Beginning in 2015, states will receive a 23 percentage point increase in the share of CHIP funding paid by the federal government, up to a cap of 100 percent. For more information, see Chapter 6, Children's Coverage.

CHRONIC CARE – Medical services provided to those with chronic conditions. Contrast with Acute Care.

CHRONIC CONDITION – A condition that is not expected to improve, that lasts a year or longer or recurs, and may result in long-term care needs. Examples include Alzheimer's disease, arthritis, diabetes, epilepsy and some mental illnesses.

CLAWBACK – Popular term for "phased-down state contribution" that describes how the federal government is recovering (or "clawing" back, from the states' perspective) money spent on Medicare-covered drugs for persons dually eligible for Medicare and Medicaid. Since January 2006, states have made monthly payments to the federal Medicare program, reflecting the amount of money they spent on prescription drugs for Medicaid-eligible seniors (known as dual eligibles) before the enactment of Medicare Part D. Payments were set at 90 percent of costs in FY 2006, decreasing to 75 percent by FY 2015. However, because of the recession of 2007 – 2009, the federal government reduced the amount each state must pay from October 1, 2008 through the end of 2010. This provision was extended through June 30, 2011 by the Education, Jobs and Medicaid Assistance Act.

CLOSED PANEL/CLOSED ACCESS – A term that describes health plans in which enrollees are permitted to receive non-emergency services only through specified providers. Group- and staff-model HMOs are examples of closed panel plans.

COINSURANCE – A portion of the bill for a medical service that is not covered by the patient's health insurance policy and therefore must be paid out of pocket by the patient. Coinsurance refers to a percentage, e.g., 10 percent of the total charge up to a specified maximum. Contrast with Copayment, which is stated as a flat amount, e.g., $5 per office visit.

COMMUNITY HEALTH CLINIC / CENTER (CHC) – Organization providing comprehensive primary care to medically underserved populations, regardless of their ability to pay. These public and non-profit entities receive federal funding under Section 330 of the Public Health Service Act, as amended.

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS) PROGRAM – Enacted as part of the ACA, the CLASS program establishes a national voluntary insurance program for purchasing non-medical services and supports necessary for individuals with functional limitations to maintain community residence. HHS is to release details of the program by October 2012. Enrollment will target working adults who will be able to make voluntary premium contributions either through payroll deductions or directly. The first benefits are to be paid out to eligible beneficiaries no earlier than five years after enrollment begins.

COMMUNITY RATING – A method for setting premiums at the same price for everyone, based on the average cost of providing health services to all. The premium is not adjusted for the individual beneficiary's medical history or likelihood of using medical services. Contrast with Experience Rating and Modified Community Rating.

COMPARATIVE EFFECTIVENESS – Research that compares clinical outcomes, or the "clinical effectiveness," of alternative therapies for the same condition. Many analysts believe that comparative effectiveness research evidence can lead to better health care decisions and thus to improved quality of care, improved efficiency, and ultimately, to the potential for cost savings throughout the health system.

CO-MORBIDITY – A medical condition that exists at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions such as heart disease, end-stage renal disease and diabetes).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) – This law includes one part which entitles former employees of companies with 20 or more workers to continue to receive their employer-sponsored coverage under the group plan for up to 18 months. Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act provided a temporary subsidy of 65 percent of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and May 31, 2010.

CONSUMER-DIRECTED OR CONSUMER-DRIVEN HEALTH PLAN – A form of health insurance that combines a high-deductible health plan with tax-favored health spending accounts into which employers or individuals contribute pre-tax dollars to be used for health care purchases. These mechanisms aim to change employees from receivers of health care into purchasers by having them participate more fully in health care and cost decisions. Also see Health Reimbursement Arrangement and Health Savings Account.

CONSUMER PRICE INDEX (CPI) – A statistical measure of the annual change in cost to workers of purchasing a market basket of goods and services. It is expressed as a percentage of the cost of these goods and services during a base period. CPI is also known as retail price index or cost-of-living index.

CONTINUING CARE RETIREMENT COMMUNITY (CCRC) – Housing community designed to provide different levels of long-term care under contract. Services usually include home care, support in an assisted living facility and care in a nursing home.

CONVERSION PRIVILEGE – Right given to an insured person under a group insurance contract to change coverage, without evidence of medical insurability, to an individual policy upon termination of the group coverage. Conversion privileges are guaranteed to many workers under the Consolidated Omnibus Budget Reconciliation Act of 1985, and to others under the Health Insurance Portability and Accountability Act of 1996.

COORDINATION OF CARE – A set of mechanisms that ensure patients and clinicians have access to, and take into consideration, all required information on a patient's conditions and treatments to ensure that the patient receives appropriate health care services.

COPAYMENT – A flat amount paid out of pocket per medical service, e.g., $5 per office visit. Contrast with Coinsurance.

CORE MEASURES – Specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction.

COST SHARING – Any out-of-pocket payment the patient makes for a portion of the costs of covered services. Deductibles, coinsurance, copayments and balance bills are types of cost sharing.

COST SHIFTING – The practice by which a seller of a health service, such as a hospital, increases charges for some payers to offset losses due to uncompensated or indigent care or lower payments from other payers.

CRITICAL ACCESS HOSPITAL (CAH) – Limited-service hospital located in rural areas and meeting certain size, location and other requirements. CAHs are subject to less rigorous staffing standards and receive reimbursement from Medicare based on their actual costs, rather than by the more common (and less favorable) payment tied to average costs for treating a particular diagnosis.

CROSS-SUBSIDY – The concept of certain purchasers paying more for medical services than they otherwise would so that others can pay less (or nothing at all), or another activity can be funded. In the U.S. health system, this mechanism has been used to pay for medical services for the poor and uninsured, medical education and research.

CROWD-OUT – A phenomenon whereby public health coverage programs encourage some employers to drop health coverage, urging their employees instead to take advantage of the subsidies available to them in the public program.

CUSTODIAL (LONG TERM) CARE – Long-term care services which do not seek to cure, provided during periods when the medical condition of the patient is not changing or does not require continued delivery by medical personnel.

D

DEDUCTIBLE – A fixed amount, usually expressed in dollars in the form of an annual fee, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

DEFENSIVE MEDICINE – The practice of health care providers ordering tests that may not be necessary to over-protect themselves from potential malpractice lawsuits. Said by some to be a major cause of high health care costs.

DEFICIT REDUCTION ACT OF 2005 (DRA) – Act which made significant changes to the Medicaid program - for example, allowing states to increase premiums and cost-sharing for families and to base benefits on private plans. The law also tightened long-term care asset transfers and capped the exemption for home equity at $500,000. Another DRA provision requires Medicaid beneficiaries to show proof of citizenship upon applying for or renewing their benefits. For more information, see www.kff.org/medicaid/7465.cfm.

DEFINED BENEFIT – A health insurance model used by an employer or government program where specified health services covered under the plan are standardized and guaranteed. The cost of providing the standard benefits may fluctuate. One example of a defined benefit plan is traditional Medicare. Contrast with Defined Contribution.

DEFINED CONTRIBUTION – A health benefit model used by employers or government programs where health services covered may fluctuate based on choice of plan, but the employer or government contributes a set amount (percentage or dollar amount) towards the purchase of the selected health plan. A defined contribution plan limits the financial liability of employers or the government, because the contribution is defined, or fixed. Contrast with Defined Benefit.

DELIVERY SYSTEMS – Networks of providers and payers that provide care and compete with other systems for enrollees. Systems may include hospitals, physicians and other providers and sites offering a full range of preventive and treatment services. Also known as coordinated care networks, community care networks and integrated health systems.

DIAGNOSIS-RELATED GROUP (DRG) – A way of determining payments to hospitals, used under Medicare's prospective payment system (PPS) and by some other public and private payers. The DRG system classifies patients into groups based on the principal diagnosis, treatments and other relevant criteria. Hospitals are paid the same for each case classified in the same DRG, regardless of the actual cost of treatment.

DIRECT GRADUATE MEDICAL EDUCATION PAYMENT – Medicare payment to approved teaching hospitals to help cover the direct costs of training residents to become board-eligible in their field. Hospitals receive full payments to help cover resident salaries, fringe benefits and compensation for attending physicians, for residents in their initial residency period (the minimum number of years required to qualify for board certification in that specialty) and half payments for residents who have completed their initial training and are sub-specializing. Direct GME payments vary significantly among hospitals and depend on the number of residents at the hospital, the hospital specific per resident amount and the size of the hospital's inpatient Medicare population. For more information, see www.cogme.gov. Also see Graduate Medical Education Payment and Indirect Medical Education Adjustment.

DIRECT-TO-CONSUMER (DTC) ADVERTISING – The use of mass media (television, newspapers, magazines, etc.) and other forms of reaching the general public. DTC advertising is often used by the pharmaceutical industry to promote their products. These advertisements must meet certain standards under federal regulations.

DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT – An increased payment under Medicare's prospective payment system or under Medicaid for hospitals that serve a relatively large number of low-income uninsured patients.

DOUGHNUT HOLE – Coverage gap in Medicare Part D prescription drug coverage, as originally enacted, where beneficiaries enrolled in Part D paid 100 percent of their prescription drug costs after their total drug spending exceeded an initial coverage limit until they qualified for catastrophic coverage. Beginning January 1, 2011, ACA shrinks the doughnut hole by reducing beneficiary copayments each year, until the doughnut hole is essentially eliminated by 2020. See Chapter 7, Medicare, for details.

DRUG REIMPORTATION – The process by which individuals or groups purchase from other countries pharmaceuticals that were originally produced in the U.S. and exported for consumption abroad. Because many other countries have lower drug prices than the U.S., this process can save consumers money on drugs for personal use. Reimportation can occur either by traveling to another country to purchase drugs (e.g., driving to Canada), or by purchasing drugs over the Internet or by mail from foreign pharmacies. Though traditionally not the subject of law enforcement, most reimportation violates U.S. federal drug safety laws.

DUAL ELIGIBLE – A Medicare beneficiary who also receives either a full range of Medicaid benefits offered in his or her state, or help with Medicare out-of-pocket expenses, usually through Medicaid. Also see Medicare Savings Programs, Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary. To promote better coordination of Medicare and Medicaid services for dual eligibles, the ACA creates a new Federal Coordinated Health Care Office – an "Office of Duals" -- within the Centers for Medicare & Medicaid Services.

DURABLE MEDICAL EQUIPMENT (DME) – Medical devices such as wheelchairs, oxygen tanks and apnea monitors.

E

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) – A range of services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, as well as vision, hearing, and dental problems. Services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, whether or not the state Medicaid plan covers those services for adult beneficiaries.

ELECTRONIC HEALTH RECORD (EHR) – Some in the health care field consider the term "electronic health record" to be virtually identical to "electronic medical record" (see below). Others consider an electronic health record to be a more patient-oriented Web-based set of information about the patient and his or her care, easily accessible by the patient and owned by the patient.

ELECTRONIC MEDICAL RECORD – A computer-based record containing details about a patient's encounter with a health care provider or facility, such as the patient's chief complaint, vital signs, medical history, medical orders, plans and prescriptions. An EMR is a legal document and must meet all of the statutory and regulatory requirements for paper medical records. It is owned by a professional practice, hospital or other health care facility. Also known as a computerized patient record. Contrast with Electronic Health Record.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) – Enacted in 1974, ERISA was primarily designed to secure workers' pension rights. The law established federal reporting and disclosure requirements for most private employee health plans. Under ERISA, companies that pay for their workers' health benefits directly (e.g., by self-insuring and assuming all or most financial risk) are exempt from state insurance regulations and taxes. ERISA also limits workers' ability to sue their insurer. For more information visit: http://www.dol.gov/dol/topic/health-plans/erisa.htm.

EMPLOYER HEALTH CARE TAX CREDIT – An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from their federal taxes. These tax credits are typically "refundable," so they are available to organizations with no federal tax liability. The ACA includes a tax credit for small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees and average annual wages of less than $50,000.

"EMPLOYER MANDATE" – An approach that requires all employers to provide health care benefits to their workers or pay a fee (see "Pay or Play" below) that contributes to the cost of covering them. The ACA creates a type of employer mandate, in that employers with 50 or more employees who don't offer coverage as of January 1, 2014 will have to pay a fee per full-time employee.

EMPLOYER PAY-OR-PLAY – An approach requiring employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Currently, two states, Massachusetts and Vermont, and the City of San Francisco impose pay-or-play requirements on employers .

EMPLOYER-SPONSORED INSURANCE (ESI) – A voluntary system in which employers choose to provide health insurance for employees.

END-STAGE RENAL DISEASE (ESRD) – Kidney disease that is severe enough to require lifetime dialysis or a kidney transplant. People of all ages who have ESRD are eligible for Medicare.

ENTITLEMENT PROGRAM – A program, such as Medicare and Medicaid, for which people who meet eligibility criteria have a right to benefits. Changes to eligibility criteria and benefits require legislation. For Medicare and Medicaid, the federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

ENTERPRISE LIABILITY – Proposal to hold hospitals or health maintenance organizations liable for negligent harm in medical malpractice cases, rather than holding individual physicians liable.

ESSENTIAL HEALTH BENEFITS – A benchmark level of benefits created by the ACA that is meant to ensure a health plan provides a comprehensive set of services. Plans both within and outside of the health insurance exchanges will be required to offer at least this level of coverage. Cost-sharing will be limited to the current HSA limits ($5,950 for individuals and $11,900 for families in 2011.) The Secretary of Health and Human Services is required to define and annually update the benefit package.

EVIDENCE-BASED MEDICINE – The use of current best clinical research evidence in making decisions about the care of individual patients, often with the assistance of information technology.

EXPERIENCE RATING – Process of determining insurance premiums for a group that is based wholly or partially on that particular group's past use of services and expenses incurred. Contrast with Community Rating and Modified Community Rating.

F

FAMILY CAREGIVER – Spouses, daughters and daughters-in-law, sons and other relatives and friends who volunteer to help with personal care, medication management and a range of household and financial matters. Sometimes referred to as "informal caregiver."

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) – Health care plans offered to federal civilian employees who can annually choose among a number of approved, community-rated private health insurance plans. The federal government pays a major portion of the cost of the coverage. For more information, including eligibility requirements and premiums for each health plan—in total and amounts paid on the employee's behalf—go to http://www.opm.gov/Insure/health/index.asp.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) – Percentage used to determine the amount of federal matching funds for state Medicaid expenditures. Before the recession of 2008 – 2009, the FMAP was not less than 50 percent or more than 80 percent. Congress increased the federal match in the American Recovery and Reinvestment Act of 2009 to help states during the recession, and later extended increased FMAP payments through June 2011. For more information go to http://aspe.hhs.gov/health/fmap.htm.

FEDERAL POVERTY GUIDELINE – The federal government's working definition of poverty that is used as the reference point to determine eligibility for certain public programs, including Medicaid and the Children's Health Insurance Program. Sometimes called Federal Poverty Level/Line (FPL). (The poverty guidelines are different from the U.S. Census Bureau's "poverty thresholds," which are used for Census statistical purposes.).

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) – Facilities that have been approved by the government for a program to provide low cost health care. They include community health centers, tribal health clinics, migrant health centers, rural health centers and health centers for the homeless.

FEE SCHEDULE – A complete listing of fees used by health plans to pay doctors or other providers.

FEE-FOR-SERVICE (FFS) – A method of paying health care providers a fee for each medical service rendered, rather than paying them salaries or capitated payments.

FIRST-DOLLAR COVERAGE – Insurance plans that provide benefits without first requiring payment of a deductible.

FISCAL INTERMEDIARY – A private contractor that pays hospital bills on behalf of Medicare.

FISCAL YEAR (FY) – The 12-month period used for calculating annual fiscal spending, which parallels the federal government's annual budget cycle. The U.S. government fiscal year runs from October 1 of the previous year to September 30 of the calendar year for which the fiscal year is numbered. States' fiscal years do not always correspond to the federal fiscal year.

FLEXIBLE SPENDING ACCOUNT/ARRANGEMENT (FSA) – An employee benefit program that enables the employee to set aside pre-tax money to be used for certain health care and dependent care expenses.

FORMULARY – A list of selected pharmaceuticals and their appropriate dosages created by health insurance plans and state Medicaid programs, which are usually intended to include a broad array of prescription drugs that are also cost-effective for patient care. Physicians are often required or urged to prescribe from the formulary developed by the insurance plans, pharmacy benefit managers or health maintenance organizations with which they are affiliated.

G

GATEKEEPER/CARE MANAGER – A health care professional, usually a primary care physician, who coordinates, manages, and authorizes all health services provided to a person covered by certain types of health plans. Unless an emergency exists, the gatekeeper generally must pre-authorize referrals to specialists, hospitalizations and lab and radiology tests.

GLOBAL BUDGETING – A fixed maximum expenditure for a defined set of health care services for a covered population. Global budgets are intended to constrain both the level and rate of increase in health care costs by limiting them directly.

GRADUATE MEDICAL EDUCATION (GME) PAYMENT – Medicare payment to approved teaching hospitals to cover the costs of training residents. The GME payment comprises both the direct GME payment, which pays for the direct costs of training residents, and the Indirect Medical Education Adjustment, which pays for the increased operating costs of a teaching hospital. For more information about GME, see www.cogme.gov.

GREEN HOUSE® – Small communities of elders and staff set in a home-like environment that function as long-term care facilities. The centers provide the assistance and support necessary for each patient, but focus on social living, rather than on medical care.

GRIEVANCE – In a health policy sense, a complaint filed because of dissatisfaction with the quality of care by a provider or with customer service or some other action by a health plan. Medicare fee-for-service, Medicare health maintenance organizations and Medicare Part D prescription drug plans, as well as Medicaid and most other health plans, have formal procedures for handling and responding to grievances. If a Medicare beneficiary files a grievance against a hospital, a Quality Improvement Organization will review the case and guarantee the patient's stay, possibly free-of-charge, until the review has been completed. Under the ACA, all consumers will have the right to appeal decisions, including coverage denials and rescissions, made by their health plans. Also see Appeal.

GROUP INSURANCE – Health insurance offered through business, union trusts or other groups and associations. The policy holder is generally the employer or other entity. This system of health insurance is the most common in the United States.

GROUP-MODEL HMO – A health maintenance organization (HMO) that contracts with a single multi-specialty medical group to provide care for HMO members. The HMO compensates the group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients. Also see HMO, Staff-Model HMO and Network-Model HMO.

GUARANTEED ISSUE/RENEWAL – A requirement that health plans cannot reject coverage for an applicant based on the person's medical history. Under the ACA, guaranteed issue for new coverage and guaranteed renewability for existing coverage is the law of the land as of January 1, 2014. For those under age 19, the provision went into effect September 23, 2010.

H

HEALTH CARE COOPERATIVE (CO-OP) – A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels. The ACA contains loans and grants for the development of new nonprofit health cooperatives to be sold as qualified health plans through state insurance exchanges in the individual and small group insurance markets.

HEALTH COVERAGE TAX CREDITS – A refundable tax credit that is paid on a monthly basis, or on a yearly basis when a person files their tax return, to help certain workers, retirees and their families pay for health insurance premiums. Under the ACA, certain small businesses are eligible for tax credits to offset part of the cost of covering their workers.

HEALTH INFORMATION TECHNOLOGY – An umbrella term (which encompasses electronic health records and personal health records) to indicate the use of computers, software programs, electronic devices and the Internet to store, retrieve, update and share information about patients' health electronically.

HEALTH INSURANCE EXCHANGE/CONNECTOR – A mechanism that creates a single marketplace facilitating the buying and selling of private health insurance. Similar to a stock exchange or a farmers market where buyers and sellers are brought together, the system is intended for individuals, small businesses, and their employees, while maintaining existing employer-based access to health insurance. The Affordable Care Act calls for the creation in every state of exchanges through which individuals who are U.S. citizens, legal residents, and businesses can buy coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – A 1996 federal law that provides some protection for employed persons and their families against discrimination in health coverage based on past or present health. Generally, the law guarantees the right to renew health coverage, but does not restrict the premiums that insurers may charge. HIPAA does not replace the states' role as primary regulators of insurance. HIPAA also requires the collection of certain health care information by providers and sets rules designed to protect the privacy of that information. For more information, see www.hhs.gov/ocr/hipaa/.

HEALTH MAINTENANCE ORGANIZATION (HMO) – A managed care plan that combines the function of insurer and provider to give members comprehensive health care from a network of affiliated providers. Enrollees typically pay limited copayments and are usually required to select a primary care physician through whom all care must be coordinated. HMOs generally will not reimburse all costs for services obtained from a non-network provider or without a primary care physician's referral. HMOs often emphasize prevention and careful assessment of medical necessity. See Group-Model HMO, Network-Model HMO and Staff-Model HMO.

HEALTH OPPORTUNITY ACCOUNT (HOA) – A type of health savings account for Medicaid beneficiaries created by the Deficit Reduction Act of 2005 (see glossary). States may deposit annual sums of up to $2,500 per adult and $1,000 per child into the account, to be used to pay for medical expenses not covered by the high deductible health plan with which the account is coupled. Compare to Health Savings Account and Health Reimbursement Arrangement.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) – A set of standardized measures of health plan performance allowing comparisons on quality, access, patient satisfaction, membership, utilization, finance and health plan management. HEDIS was developed by employers, health maintenance organizations (see glossary) and the National Committee on Quality Assurance.

HEALTH PROFESSIONAL SHORTAGE AREA – A geographic area determined by the U.S. Public Health Service to have a shortage of physicians and other health professionals. Physicians who provide services in HPSAs qualify for a Medicare bonus payment or student loan forgiveness.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) – An agency of the U.S. Department of Health and Human Services that works to improve access to health care services for people who are uninsured, isolated or medically vulnerable. Its goals, pursued through more than 100 programs, are to improve access, strengthen the health workforce, build healthy communities and improve health equity.

HEALTH REFORM LAW (formally known as the Patient Protection and Affordable Care Act or simply the Affordable Care Act, ACA) **–** Law enacted in March 2010, phasing in major expansions in insurance coverage, changes in insurance rules, and delivery system changes, over the next several years.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – A type of health insurance plan also known as "health reimbursement account" or "personal care account," HRAs are tax-preferred accounts with funds established by employers to reimburse employees for qualified medical expenses; often HRAs are paired with a high-deductible health plan. An HRA may be used by an employee to pay for medical coverage until funds are exhausted. Once the deductible is reached, normal coverage begins. Any unused funds are rolled over at the end of the year, but do not follow the employee once he or she changes jobs. Compare to Health Savings Account.

HEALTH SAVINGS ACCOUNT (HSA) – A type of health insurance plan similar to HRAs (see above), but which is owned by workers. An HSA is a tax-preferred savings account and is paired with a high-deductible health plan. Any employer can offer an HSA (or a self-employed individual can set one up on his or her own), and both employers and employees can contribute to it. The worker must pay for all services until the amount of the deductible is reached (in 2011, a minimum of $1,200 for an individual and $2,400 for family coverage). The worker can withdraw money from the HSA to pay for medical services under the deductible. Once the deductible is reached, normal coverage begins. Any unused funds are rolled over at the end of the year. Unlike HRAs, HSAs follow an employee when he or she changes jobs. Also see Health Reimbursement Arrangement and Medical Savings Account.

HIGH-DEDUCTIBLE HEALTH PLAN – Health insurance plans that have higher deductibles (see Glossary) but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least $1,200 for single coverage and $2,400 for family coverage in 2011.

HIGH-RISK POOL – A health insurance pool organized as a source of coverage for individuals who have been denied health insurance because of a medical condition, or whose premiums are significantly higher than the average due to health status or claims experience. The ACA calls for the establishment of a temporary high-risk pool in every state – run by the state or by the federal government – with premiums on a par with those in the individual market for persons without pre-existing medical problems. These pools, which exist alongside high-risk pools already in operation in many states, went into effect June 21, 2010 and will end on January 1, 2014. On the later date, coverage will be available to high-risk individuals through state health insurance exchanges.

HOME AND COMMUNITY-BASED SERVICES (HCBS) – State-designed HCBS encompass case management, adult day care, home health aide assistance, personal care, assisted living services and respite care. Section 1915(c) of the Social Security Act permits the HHS Secretary to approve Medicaid waivers that allow for long-term care services to be delivered in the community instead of institutional settings. The Deficit Reduction Act also created a capped HCBS option that allows states to offer these services without having to obtain administrative waiver approval. See Program for All-Inclusive Care of the Elderly and Medicaid. Provisions in the ACA give states incentives to expand their HCBS programs to balance spending between institutional care and HCBS.

HOMEBOUND – Condition required to receive home health care services under Medicare and generally interpreted to mean that the beneficiary cannot leave home without excessive effort and does so only infrequently, for no more than 16 hours per month for non-medical reasons.

HOME HEALTH CARE – Health services rendered in the home, including skilled nursing care, speech therapy, physical therapy, occupational therapy, rehabilitation therapy and social services. Medicare covers some home health care services if the beneficiary is homebound but does not require more than 35 hours of services per week. Medicaid pays for home health care services in 12 states.

HOME HEALTH AGENCY (HHA) – Health care provider organization that renders skilled nursing and health care services in the home. See Home Health Care and Homebound.

HOSPICE – An organization providing medical, emotional, spiritual and social help, often in the patient's own home, for those expected to live less than six months. If a person qualifies for Medicare Part A and has a terminal illness, Medicare pays for hospice care, including payment of drugs for symptom control and pain relief, hospice aide and homemaker service, and spiritual counseling, among other services. For details on covered services and payment rates, go to http://www.cms.gov/hospice to see an HHS fact sheet.

HOSPITAL INSURANCE (HI) TRUST FUND – The Part A Medicare trust fund that pays for inpatient hospital services; skilled nursing facility care for up to 100 days following hospitalization; and some care from home health providers, hospices and rehabilitation facilities for the elderly and permanently disabled. Also see Trust Fund.

HOSPITAL QUALITY ALLIANCE (HQA) – A public-private collaboration seeking to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care.

HOSPITAL REFERRAL REGION – Geographic regions used by the Dartmouth Atlas of Health Care to define regional health care markets. These regions are defined by where patients in surrounding areas are most often referred to for tertiary care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery. HRRs can cross state lines.

HYDE AMENDMENT – A federal law first enacted in 1980, and attached to appropriations bills every year since, that prohibits the use of federal Medicaid funds for abortion, except for reasons of life endangerment.

I

INCOME-RELATED PREMIUM – Premiums for Medicare Part B and Part D that apply to higher-income Medicare beneficiaries. The Medicare Modernization Act of 2003 established an income-related Part B premium requiring higher-income Medicare beneficiaries to pay a greater share of average Part B costs (35 percent to 80 percent, depending on their income). Beneficiaries are required to pay the income-related Part B premium if their income is equal to or greater than $85,000 for an individual and $170,000 for a couple in 2010. The ACA freezes the threshold for the income-related Part B premium at 2010 levels through 2019. The ACA also creates an income-related Part D premium, effective in 2011, using the same surcharge percentages and income thresholds as for Part B. Similar to the Part B premium provision, the income thresholds for the Part D income-related premium are not indexed to increase annually, thus making more beneficiaries subject to the higher premiums each year.

INDEMNITY INSURANCE – A health insurance plan that pays providers on a fee-for-service basis for delivering health care. Consumers face very few restrictions on provider selection, but may have greater financial liability in the form of deductibles and coinsurance than in many managed care plans.

INDEPENDENT PAYMENT ADVISORY BOARD – Created in the ACA, a board of 15 members appointed by the president and confirmed by the Senate for six-year terms. The board is tasked with submitting proposals to Congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the board fails to submit a proposal, the secretary of the Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The secretary is required to implement the board's (or his or her own) proposals, unless Congress adopts alternative proposals that result in the same amount of savings. The board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D.

INDEPENDENT PRACTICE ASSOCIATION (IPA) – A physician organization which typically contracts with a health maintenance organization to provide services to the HMO's enrollees. The HMO usually makes capitated payments to the IPA, but the IPA may choose to reimburse its physicians on a fee-for-service basis. Physicians can contract with other HMOs and see other fee-for-service patients.

INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT – A Medicare payment supplemental to diagnosis-related group (DRG) payments for each beneficiary inpatient stay. It is intended to compensate teaching hospitals for the various costs associated with running an academic health center that trains and employs large numbers of medical residents. Many teaching hospitals tend to treat sicker patients with less insurance coverage, requiring a more costly mix of staff, and may use more expensive and complex interventions. For more information, see www.cogme.gov. Also see Graduate Medical Education Payment and Direct Medical Education Payment.

INDIVIDUAL INSURANCE MARKET – The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

INDIVIDUAL MANDATE – A law requiring individuals to obtain health care coverage, and in some cases, forcing individuals to pay a penalty if they choose not to participate. The individual mandate of the ACA goes into effect January 1, 2014. Exemptions will granted for certain people, including American Indians, those with religious objections and those facing financial hardships.

INPATIENT – A person who is admitted to a hospital, usually for 24 hours or more.

INSTITUTE OF MEDICINE (IOM) – A nonprofit organization that works outside the framework of government to ensure scientifically informed analysis and independent guidance on matters of biomedical science, medicine and health. The institute provides unbiased, evidence-based and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society and the public at large.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS) – Activities relating to independent living, which include preparing meals, keeping a budget, purchasing groceries, performing housework and using a telephone. IADLs refer to skills beyond basic self care, or activities of daily living.

INTERGOVERNMENTAL TRANSFER (IGT) – Transfer of funds among or between different levels of government, including state-owned or operated health care providers, local governments, and non-state-owned or operated health care providers. The term is most often used in Medicaid, where transfers of governmental funds to the state Medicaid agency are used as the non-federal share to draw down federal matching funds for allowable Medicaid expenditures. States also use IGTs as the non-federal share to draw down federal matching funds for Medicaid Disproportionate Share Hospital payments.

INTEGRATED PROVIDER – A group of providers that offer comprehensive and coordinated care, and usually provide a range of medical care facilities and service plans including hospitals, physician group practices, a health plan and other related health care services.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) – An institution providing diagnosis, treatment or rehabilitation of individuals with mental retardation or related conditions. ICF/MRs provide a protected residential setting, ongoing evaluations, 24-hour supervision and health services. Under Medicaid, states may cover ICF/MR services.

J

JOINT COMMISION – A national private, nonprofit organization that accredits health care organizations and agencies and sets guidelines for these facilities.

L

LOCK-IN – Lock-in refers to the period of time an individual is required to, or agrees to, remain registered with a particular provider or group of providers, or remain enrolled in a particular health care plan.

LONG-TERM CARE (LTC) – Ongoing health and social services provided for individuals who need continuing assistance with activities of daily living and/or instrumental activities of daily living (see glossary). Services can be provided in an institution, the home or the community, and include informal services provided by family and friends as well as formal services provided by professionals or agencies. Medicaid is the primary payer of LTC services in nursing homes.

LONG-TERM CARE PARTNERSHIP PROGRAM – A program that combines private LTC insurance with special access to Medicaid. This program encourages qualified individuals to purchase a limited, and therefore more affordable, amount of LTC insurance coverage, with the assurance that they could receive additional LTC services through the Medicaid program as needed after their insurance coverage is exhausted, without having to deplete their assets to the level typically required in order to be Medicaid eligible.

LOSS RATIO – See Medical Loss Ratio

M

MANAGED CARE – A health care delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

MANDATE – Used in two senses in health policy discussions. (1) Employer or individual mandate, in which a government body imposes a requirement on some employers to help pay for insurance coverage for their workers (and perhaps their families), and/or on certain individuals to obtain coverage. (2) State mandate, a requirement imposed by states on insurance companies to include, as part of any health insurance policy they sell, coverage for a specific service, such as well baby care, or a specific provider, such as a psychologist or optometrist.

MARKET BASKET INDEX – An index of the annual change in the prices of a selection of goods and services providers used to produce health services. Also referred to as an input price index.

MEANS TEST(ING) – Determining eligibility for government benefits based on an individual's lack of means, as measured by income and/or assets. Under current Medicaid eligibility guidelines, means-testing may differ for different eligibility groups. The Medicare Prescription Drug Improvement and Modernization Act of 2003 introduced a form of means-testing in Medicare, which now sets higher premiums for higher-income seniors and provides more generous drug benefits to lower-income beneficiaries.

MEDICAID – Public health insurance program that provides coverage for low-income persons for acute and long-term care. It is financed jointly by state and federal funds (the federal government pays at least 50 percent of the total cost in each state) and is administered by states within broad federal guidelines. See Chapter 8, Medicaid, for more information.

MEDICAID WAIVER – Authority granted by the secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs or managed care, and to expand coverage to populations who are not otherwise eligible for Medicaid.

MEDICAL HOME – See Patient-Centered Medical Home

MEDICAL IRA – See Medical Savings Account

MEDICAL LOSS RATIO – The ratio of money paid out by an insurer for claims, divided by premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars was paid out for benefits, while a high loss ratio indicates that a high percentage of the premium dollars was paid out for benefits. The ACA sets minimum medical loss ratios for health plans effective Jan. 1, 2011.

MEDICAL SAVINGS ACCOUNT (MSA) – A health insurance option consisting of a high-deductible insurance policy coupled with a tax-preferred savings account. MSA policies, enacted in 1996, have been largely replaced by health savings accounts.

MEDICAL UNDERWRITING – See Underwriting

MEDICALLY NEEDY – An optional Medicaid category in which states can cover individuals and families who qualify for coverage because of high medical expenses, usually hospital or nursing home care. To qualify, individuals must be categorically eligible and their monthly incomes minus accumulated medical bills must be below state income limits for the Medicaid program. This allows Medicaid coverage for people who have extensive health care needs but too much income to be eligible for Medicaid. Also see Spend-Down.

MEDICARE – Federal health insurance program for virtually all persons age 65 and older, and permanently disabled persons under age 65, who qualify by receiving Social Security Disability Insurance. See Chapter 7, Medicare, for more.

MEDICARE ADVANTAGE – A part of Medicare designed to offer beneficiaries a choice of managed care and other private plan options. Also called Part C of Medicare, Medicare Advantage encompasses health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare HSAs, regional PPOs, and other options. Not all options are available in all areas.

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MA-PD) – Medicare Part D prescription drug coverage that is sponsored by a Medicare Advantage plan.

MEDICARE PART A – Also known as the Hospital Insurance (or HI) program, Part A of the Medicare program covers inpatient hospital care, skilled nursing care for up to 100 days after a hospitalization, home health and hospice care. It is funded by a portion of the wage tax – 2.9 percent, with employers and employees each paying 1.45 percent.

MEDICARE PART B – Also known as Supplementary Medical Insurance (or SMI), Part B of Medicare covers physician services, outpatient care and home health care after 100 visits. It is funded partly by premiums paid by beneficiaries. The rest comes from the federal government's general revenue.

MEDICARE PART D – See Medicare Prescription Drug, Improvement and Modernization Act of 2003 below.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT & MODERNIZATION ACT OF 2003 (MMA) – Legislation signed into law in December 2003 that provides seniors and disabled individuals on Medicare with a prescription drug benefit, delivered through private stand-alone prescription drug plans or managed care plans integrating Part A and Part B benefits (Medicare Advantage). The law expanded the array of Medicare managed care plans and changed payment methodologies. For more information, see http://www.kff.org/medicare/med011604pkg.cfm.

MEDICARE SAVINGS PROGRAM (MSP) – The program provides assistance through Medicaid with Medicare premiums - and sometimes cost-sharing requirements - to Medicare beneficiaries of limited income and resources who do not qualify for full Medicaid benefits. The program encompasses qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs) and other groups of beneficiaries who need help with cost-sharing to access services. For more information, visit http://www.cms.gov/DualEligible/.

MEDIGAP INSURANCE/MEDICARE SUPPLEMENTAL INSURANCE – Medigap policies are sold by private insurance companies to fill "gaps" in fee-for-service Medicare. Except in Minnesota, Massachusetts and Wisconsin, there are 10 standardized policy designs, known as Plans A through J. Plans H, I and J include limited drug coverage. No new Medigap policies that include drug coverage are now being be sold. Beneficiaries with existing Medigap policies that include drug coverage may maintain them if they wish. However, they may be subject to late enrollment penalties if they later want Part D drug benefits. For more information, visit http://www.cms.gov/Medigap/

MENTAL HEALTH PARITY ACT – An act requiring group health plans with more than 50 employees to ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than the predominant requirements and limitations placed on substantially all medical/surgical benefits. For more information, see text box in Chapter 11, Mental Health and Substance Abuse.

MISUSE – Describes care that is provided poorly or erroneously, such as wrong-site surgery. For more information, see Chapter 3, Quality for more information.

MODIFIED COMMUNITY RATING – A method for setting health insurance premiums for everyone in a state taking into account demographic variables, but not the applicant's medical history. Contrast with Community Rating and Experience Rating.

MORBIDITY – A determination of the incidence and severity of sicknesses and accidents in a well-defined class of persons.

MORTALITY – An actuarial determination of the death rate at each age as determined from prior experience.

MULTIPLE EMPLOYER WELFARE ASSOCIATION (MEWA) – A group of employers who band together for purposes of purchasing group health insurance, often through a self-funded approach. MEWAs are sometimes exempt from state benefit mandates, taxes and other regulations.

N

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) – A nonprofit association whose members comprise the insurance commissioners of the individual states and territories. NAIC members are elected or appointed state government officials who regulate the conduct of insurance agencies and agents. NAIC was delegated significant responsibilities under the ACA, including developing uniform definitions for calculating medical loss ratios and assisting HHS with establishing rate review procedures.

NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA) – An independent national organization that reviews and accredits managed care plans and measures the quality of care offered by managed care plans and other entities.

NATIONAL INSTITUTES OF HEALTH (NIH) – A part of the U.S. Department of Health and Human Services, the primary federal agency for conducting and supporting medical research. NIH scientists investigate ways to prevent disease as well as the causes, treatments, and even cures for common and rare diseases.

NETWORK-MODEL HMO – A health maintenance organization (HMO) that contracts with more than one independent physician group to provide health services. The providers may see patients who are not members of the HMO. Also see HMO, Group-Model HMO and Staff-Model HMO.

NEVER EVENT – 28 occurrences that the National Quality Forum has identified as events that should never happen in a hospital and can be prevented. These events include surgical events, product or device events, and criminal events. The Centers for Medicare and Medicaid Services (CMS) announced in January 2009 that Medicare would stop paying for three never events – wrong invasive procedures, invasive procedures performed on the wrong body part and invasive procedures performed on the wrong patient.

NURSE PRACTITIONER (NP/RNP) – A registered nurse with advanced academic and clinical experience who diagnoses and manages most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications.

O

OFFICE OF CONSUMER INFORMATION AND INSURANCE OVERSIGHT – See Center for Consumer Information and Insurance Oversight

ON LOK PROGRAM – A San Francisco project that uses an HMO model to provide all acute care and long-term care services needed by a frail elderly population at risk of nursing home placement. See Program of All-Inclusive Care for the Elderly.

OPEN ENROLLMENT – The period of time during which health insurance coverage options are offered to a specified population, regardless of health status and without medical screening. Open enrollment periods are characteristic of some Blue Cross-Blue Shield plans and health maintenance organizations, and all plans in the Federal Employees Health Benefits Program.

OPEN PANEL/OPEN ACCESS – A self-referral arrangement allowing health plan enrollees to see participating providers for specialty care without a referral from a primary care physician or other doctor.

OUT-OF-POCKET CAP/MAXIMUM – An annual limit on how much an individual has to pay in deductibles, coinsurance and copayments, excluding the premium. The ACA requires new plans offered beginning in 2014 to include an out-of-pocket maximum set at the current maximum level for contribution to health savings account, or $5,950 for an individual or $11,900 for a family policy in 2011.

OUTCOMES RESEARCH – Research that attempts to evaluate particular health services by tracking and analyzing clinical results (e.g., death, illness, ability to function) of various treatments. See also Patient Centered Outcomes Research Institute

OUTPATIENT – A person receiving medical services who has not been admitted to a hospital.

OUTPATIENT HOSPITAL SERVICES – Services provided to a hospital outpatient. They are covered by Part B for Medicare beneficiaries. For more information, see Chapter 7, Medicare.

OVERUSE – A term used when patients receive care that is not medically indicated. Typical examples are use of antibiotics to treat a cold or the use of imaging devices for someone with the first signs of lower back pain. For additional information, see Chapter 3, Quality.

P

PARTIAL CAPITATION – An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and a payment based on actual use of services. The proportions specified for these components determine the insurance risk faced by the plan.

PATIENT-CENTERED CARE – An approach that takes into consideration the patients' cultural traditions, personal preferences and values, family situations and lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need.

PATIENT-CENTERED MEDICAL HOME – An approach to providing comprehensive primary care for individuals through creating a setting that facilitates partnerships between individual patients and their personal physicians. This approach to care is aided by registries, information technology, health information exchanges and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. For additional information, visit http://www.ncqa.org/tabid/631/Default.aspx.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE – A private, nonprofit institute created in the ACA to set an agenda for, and oversee the conduct of, comparative effectiveness research in the U.S.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) – Law enacted in March 2010, phasing in major expansions in insurance coverage, changes in insurance rules, and delivery system changes. Known informally as the Affordable Care Act or ACA.

PAY FOR PERFORMANCE – A method of paying health care providers differing amounts based on their performance on measures of quality and efficiency. Payment incentives can be in the form of bonuses or financial penalties.

PAYMENT BUNDLING – A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The ACA establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.

PAYMENT REFORM – Payment reform seeks to improve current mechanisms for reimbursing providers by including rewards for provider quality in the reimbursement mechanisms. For additional information, see Chapter 1, Health Reform.

PAY OR PLAY – See Employer Pay or Play

PAYROLL TAX – A flat percentage tax collected on salaries and wages. A payroll tax of 7.65 percent on both employers and employees finances Social Security cash benefits and Medicare Part A hospital services. Of that 7.65 percent, 1.45 percent each, or a total of 2.9 percent of payroll with both employer and employee contributions, is allocated for Medicare. Funding of the ACA will come in part from higher Medicare payroll taxes on families making more than $250,000, starting in 2013.

PHARMACY BENEFIT MANAGER (PBM) – A company that contracts with insurers and employers to manage the prescription drug benefit for enrollees or employees. The vast majority of managed care plans use PBMs.

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) – Authorized through the Medicare, Medicaid, and SCHIP Extension Act of 2007, it offers a financial incentive for health care professionals to report on the quality of care that they provide.

POINT-OF-SERVICE PLAN (POS) – A managed care plan that combines features of both prepaid and fee-for-service insurance. POS plan enrollees decide whether to use network or non-network providers at the time care is needed, but usually are subject to reduced coverage and larger copayments for using non-network providers.

POVERTY LEVEL – See Federal Poverty Guidelines

PRACTICE GUIDELINES/PARAMETERS – A statement of the known benefits, risks and costs of particular courses of medical action, developed to give physicians information about treatment alternatives.

PRE-EXISTING CONDITION – A physical or mental condition of an individual which is known to the individual before an insurance policy is issued. Insurers may choose not to cover treatment for such a condition, at least for a period, may raise rates because of it, or may deny coverage altogether. Pre-existing condition exclusions are prohibited by the ACA now for children and in 2014 for adults.

PREFERRED PROVIDER ORGANIZATION (PPO) – A health care delivery system through which a number of providers contract to serve health plan enrollees on a fee-for-service basis at discounted fees. Providers agree to PPO discounts in the hope of gaining more patients. Patients may use any provider without a referral, in network or out, but have a financial incentive – for example, lower coinsurance payments – to use doctors on the preferred list.

PREMIUM – The cost of health plan coverage, not including any required deductibles or copayments. The cost of the premium may be shared between employers or government purchasers and individuals .

PREMIUM ASSISTANCE – The use of federal funds available through public health coverage programs – especially Medicaid and CHIP – to purchase or help purchase private insurance.

PREMIUM SUBSIDIES – A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income. The ACA provides premium subsidies through refundable pre-tax credits to individuals with incomes between 133 percent and 400 percent of the federal poverty level who purchase policies through the health insurance exchanges beginning in 2014.

PREMIUM SUPPORT – A health benefit model that is considered by its designers to be a hybrid of the defined contribution and defined benefit approaches. This model requires general categories of health services to be covered, but benefits could be added or deleted within limits. The employer or government then contributes a set amount of the premium for the purchased plan. Plans could set premiums at whatever dollar level they choose, with beneficiaries liable for any costs above the employer or government contribution. A Medicare demonstration designed to test a model similar to premium support began in 2010.

PREVENTIVE HEALTH SERVICES – Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (immunizations), at early detection of disease (Pap smears), and at stopping further deterioration (cholesterol-lowering medication).

PRIMARY CARE – Care at "first contact" with the health care system, including an array of non-specialist services provided by physicians, nurse practitioners, or physician's assistants – more simply, the care that most people receive for most of their problems that bother them most of the time.

PRIMARY CARE CASE MANAGEMENT, INITIATIVE, OR CLINICIAN - (PCCM/PCI/PCC) – A Medicaid managed care program in which an eligible individual may use services only with authorization from his or her assigned primary care provider. That provider is responsible for locating, coordinating, and monitoring all primary and other medical services for enrollees. Those services are usually paid on a fee-for-service basis.

PRIMARY CARE PROVIDER – A provider, usually a physician, specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practioner, physician assistant or health care clinic), who serves as the patient's first point of contact with the health care system and coordinates the patient's medical care.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) – Originally a Medicare demonstration project that replicated the model of managed care developed by On Lok Senior Health Services in San Francisco. Now a national, permanent program. PACE targets frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid. Core services include adult day care, social support, home health, hospital care, nursing home care, and case management that integrates acute and long-term care services. PACE is financed through capitated Medicare and Medicaid payments to the provider. For more information, visit http://www.cms.gov/PACE/.

PROSPECTIVE PAYMENT SYSTEM (PPS) – A method used by Medicare to pay for many services, including inpatient and outpatient hospital services as well as services provided at skilled nursing and rehabilitation facilities. Payment rates are linked to diagnosis and determined before services are rendered, rather than being based on actual costs or charges of a specific facility. Rates are intended to cover treatment costs for a typical patient with a given diagnosis and are adjusted for factors like wages and indigent care.

PROVIDER – Any health care professional or institution that renders a health service or provides a health care product. Major providers are hospitals, nursing homes, physicians and nurses.

PUBLIC HEALTH – The protection and improvement of population health by organized community effort. Public health activities are very broad and include immunization, sanitation, preventive medicine, disease control, education about reducing personal risks, occupational health and safety, pollution control, water safety, food safety, epidemiology, etc. See Chapter 12, Public Health, for more information.

PURCHASING POOL – A group of people, businesses or associations who come together to enhance their bargaining power and negotiate lower premiums from health insurance plans than they could on their own, while also pooling risks across sick and healthy individuals.

Q

QUALIFIED MEDICARE BENEFICIARY (QMB) – A person who is eligible for Medicare, has an income below 100 percent of the federal poverty level and has limited assets, who is therefore eligible to receive assistance with Medicare's cost-sharing. Under the QMB program, state Medicaid agencies are required to pay the cost of Medicare Part A and B premiums, deductibles and coinsurance.

QUALITY-ADJUSTED LIFE YEARS (QALYS) – Years of life saved by a medical technology or service, adjusted to reflect the health quality of those years (as determined by some evaluative measure). QALYs are the most commonly used unit to express results in certain cost-effectiveness analyses. A year of perfect health is considered equal to 1.0 QALY.

QUALITY IMPROVEMENT ORGANIZATION (QIO) – One of 53 groups with which Medicare contracts to monitor hospital use and quality of care received by Medicare patients in a given state or other area. For additional information, visit http://www.cms.gov/QualityImprovementOrgs/

R

RATING – The process of evaluating, or underwriting, a group or individual to determine a health insurance premium rate relative to the financial risk the person or group presents of needing health care. Key components of the rating formula include age, sex, location and plan design.

RATING BANDS – Amounts by which insurance rates for a specific class of insured individuals may vary. All states have laws regulating insurer rating practices, and many states periodically update these laws with small group market reform proposals to restrict or loosen allowable variations.

REFERRAL – A primary care doctor's written permission for a patient to see a certain specialist or to receive certain services. Required by some managed care health plans.

REFUNDABLE TAX CREDIT – A way of providing a tax subsidy to an individual or business, even if no taxes are owed (see Tax Credit). If a person owes no tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

REINSURANCE/RISK CONTROL INSURANCE – A practice allowing an insurance company (the insurer) to transfer a portion of its risks to another insurer (the reinsurer). This practice does not affect policyholder rights in any way, and the original insurer remains liable to the policyholders for benefits and claims.

RELATIVE VALUE SCALE (RVS) – An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. To calculate a fee for a particular service, the index for that service is multiplied by a constant dollar amount (known as the conversion factor). Medicare uses an RVS to calculate payments to physicians.

REPORT CARD – An assessment of the quality of care delivered by health plans, hospitals or other providers. Report cards provide information on how well a health plan treats its members, keeps them healthy and provides access to needed care. Report cards can be published by states, private health organizations, consumer groups or health plans.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) – The way Medicare determines how much it will pay physicians, based on the resource costs needed to provide a Medicare-covered service. The RBRVS is calculated using three components: physician work, practice expense and professional insurance. The Medicare payment to physicians is determined by multiplying the combined costs by a conversion factor set by the Centers for Medicare and Medicaid Services, adjusted for geographical differences in the cost of resources. Physician work typically accounts for 50 percent of the value while practice expense accounts for 45 percent.

RESPITE CARE – Short-term personal care given to a frail elder or person with disabilities, to substitute for assistance usually provided by a family caregiver.

RISK – The probability of financial loss, based on the probability of having to provide services to a patient or patient population at a cost that exceeds the payments received. Under capitation payment systems, providers share the risk that is borne by insurers.

RISK ADJUSTMENT – Increases or reductions in payment made to a health plan on behalf of a group of enrollees to compensate for health care expenditures that are expected to be higher or lower than average.

RISK SELECTION – Enrollment choices made by health plans - or by enrollees - on the basis of perceived risk relative to the premium to be paid.

RISK SHARING – A method by which the financial risk of covering a group of enrollees is shared by plan sponsors and purchasers, typically managed care organizations and states. In contrast, indemnity plans assume all risk of providing care paid for through insurance premiums which belong solely to the insurance company.

S

SAFETY NET PROVIDERS – Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospitals, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

SECTION 125 PLAN – A Section 125 plan provides participants an opportunity to receive certain benefits, such as reimbursement for some out-of-pocket medical expenses, on a pretax basis. It is a separate written plan, maintained by an employer for employees, that meets the specific requirements of Section 125 of the Internal Revenue Code.

SELF-EMPLOYED DEDUCTION FOR HEALTH INSURANCE – Self-employed taxpayers and their families can deduct all their payments for health insurance, including insurance premiums, when figuring their annual income for tax purposes, to the extent these payments exceed 7.5 percent of adjusted gross income.

SELF-INSURANCE – Large and medium-size companies often assume all or most financial risks of providing health insurance to their workers, as opposed to purchasing insurance coverage from commercial carriers (and having the carrier assume all risk). Claims processing is often handled through an administrative services contract with an independent organization, often an insurance company.

SINGLE PAYER SYSTEM – A health care system, either at the national or state level, which would designate one entity (usually the government) to function as the central purchaser of health care services. Canadian provinces operate health insurance coverage for residents under this system.

SKILLED NURSING FACILITY (SNF) – An institution that offers skilled services similar to those given in a hospital, such as intravenous injections and physical therapy given by professional staff, to aid rehabilitation following hospitalization of patients who have been discharged. SNFs differ from nursing homes or nursing facilities, which are intended primarily to support elderly and disabled individuals in the tasks of daily living (custodial care). Medicare does not cover custodial care in nursing homes; however, Medicare does cover skilled nursing care, rehabilitation and associated custodial care in SNFs. Medicaid covers care in all Medicaid-certified nursing facilities.

SMALL GROUP MARKET – A private insurance market, regulated by state government, where firms with two to 50 employees can purchase health insurance for their employees.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) – Financed with Social Security taxes, SSDI provides cash assistance to people who are permanently disabled and unable to work, and who previously worked and paid Social Security payroll taxes. Although the number of work credits required to qualify for SSDI depends on the age of disability onset, one must typically have 40 credits, of which 20 must be from the last 10 years (four work credits can be earned per year). The size of the monthly benefit depends on the beneficiary's earnings record. Widows, widowers and adults who are blind or disabled since childhood are also eligible for SSDI.

SOCIALIZED MEDICINE – A system of health care in which all health personnel and health facilities, including doctors and hospitals, work for the government and draw salaries from the government. Doctors in the U.S. Veterans Administration and the Armed Services are paid this way. Veterans and U.S. military hospitals are also supported this way. Examples also exist in Great Britain and Spain.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) – A person who is eligible for Medicare, has an income of between 100 to 120 percent of the federal poverty level and has limited assets and is eligible to receive cost-sharing assistance if enrolled in the Specified Low-Income Medicare Beneficiary program. Under the SLMB program, state Medicaid agencies are required to pay the beneficiary's Part B premiums, but not deductibles or copayments. Also see Qualified Medicare Beneficiary. See http://www.cms.gov/DualEligible/ for more information.

SPEND-DOWN – Process by which individuals in many states can qualify for Medicaid because high medical expenses, usually hospital or nursing home care, reduce their monthly income to below state income limits for the Medicaid program. The amount that each individual must "spend down" is determined at the time eligibility is determined. Also see Medically Needy.

STAFF-MODEL HMO – A health maintenance organization (HMO) that delivers health services through salaried physicians who are employed by the HMO exclusively to care for HMO enrollees. Also see HMO, Group-Model HMO and Network-Model HMO.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) – A federal program that provides funding to states to provide Medicare beneficiaries and other consumers with free health insurance counseling and assistance. See http://goo.gl/TIkrX for more information.

STATE MANDATE – State coverage laws requiring private insurers to cover specific services (such as well-baby care) or reimbursement for specific providers (such as psychologists). The Employee Retirement Income Security Act generally exempts self-insured companies from these requirements.

STATE PHARMACY ASSISTANCE PROGRAM (SPAP) – State-funded program providing pharmacy benefits to seniors and other low-income groups. Before the enactment of Medicare Part D, 22 states funded SPAPs while six states operated waiver programs funded jointly by state and federal governments through Medicaid (see Medicaid 1115 Waiver). With Part D in operation, most states have begun providing wrap-around benefits to coordinate and ease the enrollment of their Medicare beneficiaries by, for example, covering deductibles, co-insurance or the gap in Medicare Part D coverage.

STOP-LOSS – See Out-of-Pocket Cap

SUBSTANCE ABUSE – A maladaptive pattern of using certain drugs, alcohol, medications, and toxins that leads to clinically significant impairment or distress.

SUBSTANCE DEPENDENCE – When a person continually uses a particular substance, resulting in compulsive substance-taking behavior, tolerance for the substance, and withdrawal symptoms if the person stops using the substance.

SUPPLEMENTAL MEDICAL INSURANCE – Any private health insurance plan held by a Medicare beneficiary that is purchased to fill in "gaps" in traditional Medicare coverage, or to finance cost-sharing requirements, e.g., Medicare's hospital deductible. Among the most common types of supplemental insurance are some employer-sponsored retiree coverage and Medigap insurance (see glossary).

SUPPLEMENTAL SECURITY INCOME (SSI) – A federal income support program for low-income disabled, aged and blind individuals. Eligibility for SSI monthly cash payments does not depend on previous employment or contributions to a trust fund. Eligibility for SSI usually confers eligibility for Medicaid.

SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND – The Medicare trust fund that pays for physician procedures and treatments delivered in hospital outpatient departments, ambulatory surgical centers, and other non-hospital facilities; most home health care services; durable medical equipment such as wheelchairs; and the new prescription drug benefit. The SMI account is financed with beneficiary premiums (25 percent) and general revenues (75 percent).

SUSTAINABLE GROWTH RATE (SGR) – The formula for determining annual targets for spending on physicians' services under Medicare, established by the Balanced Budget Act of 1997. The SGR is intended to control growth in total Medicare expenditures for physician services. If expenditures exceed the SGR target, the fee schedule update is decreased. Four factors are used to calculate the SGR: (1) average percent change in physician fees; (2) change in the average number of fee-for-service beneficiaries; (3) 10-year average annual growth in GDP per capita; and (4) change in expenditures due to new laws or regulations.

T

TAX CREDIT – A flat amount that can be subtracted from taxes owed. Under the 2010 health care reform law, tax credits are available to some small businesses to subsidize their workers' health insurance premiums. A tax credit is more valuable than a tax deduction of the same amount, since the deduction reduces taxable income, not taxes owed, by the amount of the deduction.

TAX DEDUCTION – An amount that can be subtracted from taxable income if spent on a specific purpose. Currently, businesses and the self-employed can deduct the cost of health insurance provided to employees, but health expenses (including insurance) are a deduction for families with group health insurance only after they reach 7.5 percent of income.

TAX PREFERENCE (FOR HEALTH BENEFITS) – Employer-paid health benefits are treated under federal tax law as a deductible business expense for the employer, and excluded from taxable income for the worker. This creates incentives for some employers and workers to prefer extra compensation in the form of more health coverage rather than wages.

TERTIARY CARE – Health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly sophisticated technologies and facilities.

THERAPEUTIC SUBSTITUTION – Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration has determined to be equivalent; the substitute has the same active ingredient with the same absorption rate as the original drug. Often, this results in prescribing the less costly compound.

THIRD PARTY ADMINISTRATOR (TPA) – A professional firm that provides administrative services to employers who want to self-insure their employees. The TPA does not underwrite the financial risk of providing coverage.

THIRD PARTY PAYER – Organization, public or private, that pays or insures medical expenses on behalf of enrollees. An individual pays a premium, and the payer organization pays providers' actual medical bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

TRADE ACT HEALTH INSURANCE SUBSIDY – Premium subsidy program that covers a portion of the cost of health insurance for early retirees, their families and other workers who have lost their employer-sponsored health coverage as a consequence of company failure due to trade practices or bankruptcy. The subsidy to former workers is provided in the form of a federal tax credit either to be claimed when the income tax return is filed, or sent directly to the beneficiary's health insurance provider each month.

TRANSITIONAL MEDICAL ASSISTANCE (TMA) – Medicaid coverage for up to one year for families leaving welfare to become self-supporting through work. During this transition period, states are required to continue Medicaid benefits even if earnings increase. See http://opencrs.com/document/RL31698/ for more information.

TRANSPARENCY – In health care, usually, the process of collecting and reporting health care cost, performance and quality data in a format that can be accessed by the public. It is intended to improve individual decision-making, or the delivery of services, or both, and ultimately to improve the health care system as a whole.

TRIAGE – The classification of sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

TRICARE – Program providing medical care to the dependents of active duty members of the military and to retired members of the military. Formerly known as the Civilian Health and Medical Program (CHAMPUS), the program is run by the Department of Defense. For more information, see www.health.mil/.

TRUST FUNDS – Federal trust funds are created in the U.S. Treasury to account for all program income, such as Social Security and Medicare taxes, and disbursements, such as benefit payments and program administrative costs. Revenues not needed in a particular year are invested in special non-marketable government securities; therefore, the trust funds represent the total value, including interest, of all prior program annual surpluses and deficits. There are two Medicare trust funds: the Hospital Insurance (HI) Trust Fund, which pays for inpatient hospital and related care, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for physician and outpatient services. Medicare Part D prescription drug expenditures are paid out of the SMI Trust Fund. See Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund in glossary.

U

UNCOMPENSATED CARE – Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes both charity care, which is provided without the expectation of payment, and bad debt, for which the provider has made an unsuccessful effort to collect payment due from the patient.

UNDERINSURED – People with public or private insurance policies that do not cover all necessary health services, resulting in out-of-pocket expenses that often exceed their ability to pay.

UNDERUSE – The failure to provide a health care service when it would have produced a favorable outcome for a patient. Standard examples include failure to provide appropriate preventive services to eligible patients (e.g., Pap smears, flu shots for elderly patients, screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for asthmatics; aspirin, beta-blockers and lipid-lowering agents for patients who have suffered a recent myocardial infarction).

UNDERWRITING – The process by which health insurers decide whether or not to accept an individual's application for insurance, and, if the applicant is accepted, what conditions and rate to apply. Underwriting is also applied to small employers. If the insurer decides that a particular individual or group poses greater than normal financial risks, it might charge higher premiums, offer more limited benefits, or refuse to pay for services relating to a particular "pre-existing" condition.

UNIVERSAL COVERAGE – Health insurance coverage for all people, through either public or privately funded programs.

UTILIZATION REVIEW (UR) – An insurer's review of health care services - particularly specialist referrals, emergency room use and hospitalizations - to evaluate their appropriateness, necessity, and quality. The review can be performed before, during, or after the delivery of care.

V

VOUCHER – In various health reform proposals, a certificate or fixed dollar amount that is provided to persons, which is used to pay all or part of the cost of health insurance or services.

W

WELLNESS PLAN/PROGRAM – Employment-based program to promote health and prevent chronic disease. Goals of these programs include: reducing health care costs, sustaining and improving employee health and productivity and reducing absenteeism due to illness.

Y

YOUNG ADULT HEALTH PLAN – Health plans designed to meet the needs of young adults. These plans tend to offer lower premiums in exchange for high deductibles and/or limited benefit packages.

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AARP - Medicare RX	www.aarp.org/medicareRx
AARP Drug Benefit Calculator	http://sites.stockpoint.com/AARP/drugbenefit.asp
AARP Public Policy Institute	www.aarp.org/research/ppi/
AcademyHealth	www.academyhealth.org
Access to Benefits Coalition	www.accesstobenefits.org
Administration on Aging, HHS	www.aoa.gov
AdvaMed	www.advamed.org
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Agency for Healthcare Research and Quality	www.ahrq.gov
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America's Promise	www.americaspromise.org
AMERIGROUP	www.amerigroupcorp.com
Annie E. Casey Foundation	www.aecf.org
Asian and Pacific Islander American Health Forum	www.apiahf.org
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Association of Maternal & Child Health Programs	www.amchp.org
Association of State and Territorial Health Officials	www.astho.org
Avalere Health	www.avalerehealth.net
Bazelon Center for Mental Health Law	www.bazelon.org
BenefitsCheckUpRx (NCOA)	www.benefitscheckup.org
Black Women's Health Imperative	www.blackwomenshealth.org
Bloomberg School of Public Health, Johns Hopkins University	www.jhsph.edu
Blue Cross Blue Shield Association	www.bcbs.com
Boston University School of Management	http://management.bu.edu/index.html
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Bright Futures	http://brightfutures.aap.org/web/
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California HealthCare Foundation	www.chcf.org
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CDC: Emergency Preparedness and Response	www.bt.cdc.gov
Center for Biosecurity, University of Pittsburgh	www.upmc-biosecurity.org
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Center for Health Care and Policy Research, Penn State University	www.hhdev.psu.edu/chcpr/
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Center for Health Transformation	www.healthtransformation.net
Center for Infectious Disease Research and Policy, University of Minnesota	www.cidrap.umn.edu
Center for Medical Consumers	www.medicalconsumers.org
Center for Medicare Advocacy	www.medicareadvocacy.org
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Center for Mental Health Services, SAMHSA	http://mentalhealth.samhsa.gov/cmhs/
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Center on an Aging Society, Georgetown University	http://ihcrp.georgetown.edu/agingsociety/
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CMS Resources for Partners	www.cms.hhs.gov/partnerships
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Cross Cultural Training, White Memorial Medical Center	http://76.163.184.36/physicians/medical_education/residencies/family/curriculum.php
Dartmouth College Dept. of Economics	www.dartmouth.edu/~economic
Denver Health	www.denverhealth.org
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DHHS Office of Minority Health	www.omhrc.gov
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Economic Research Initiative on the Uninsured	www.umich.edu/~eriu/
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The ERISA Industry Committee	www.eric.org
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National Association of State Medicaid Directors	www.nasmd.org
National Association of State Mental Health Program Directors	www.nasmhpd.org
National Association of State Units on Aging	www.nasua.org
National Black Caucus of State Legislators	www.nbcsl.org
National Black Child Development Institute	www.nbcdi.org
National Black Nurses Association	www.nbna.org
National Cancer Institute Surveillance, Epidemiology, and End Results	http://seer.cancer.gov
National Center for Assisted Living	www.ncal.org
National Center for Chronic Disease Prevention and Health Promotion	www.cdc.gov/nccdphp/
National Center for Cultural Competence	http://gucchd.georgetown.edu/nccc/
National Center for Policy Analysis	www.ncpa.org
National Center for Primary Care, Morehouse School of Medicine	www.msm.edu/NCPC/
National Center on Addiction and Substance Abuse at Columbia University	www.casacolumbia.org
National Center on Caregiving, Family Caregivers Alliance	www.caregiver.org
National Center on Minority Health and Health Disparities	http://ncmhd.nih.gov
National Coalition on Health Care	www.nchc.org
National Committee for Quality Assurance	www.ncqa.org
National Committee to Preserve Social Security and Medicare	www.ncpssm.org
National Conference of State Legislatures	www.ncsl.org
National Conference of State Legislatures, Health Program	www.ncsl.org/programs/health/health.htm
National Consumer Voice for Quality Long-Term Care	www.theconsumervoice.org
National Council on Aging	www.ncoa.org
National Council on Disability	www.ncd.gov
National Diabetes Education Program	www.ndep.nih.gov
National Disability Rights Network	www.napas.org
National Disaster Medical System, DHS	www.oep-ndms.dhhs.gov
National Governors Association	www.nga.org
National Health Law Program	www.healthlaw.org
National Health Policy Forum	www.nhpf.org
National Hispanic Medical Association	www.nhmamd.org
National Immigration Law Center	www.nilc.org
National Institute for Health Care Management	www.nihcm.org
National Institute of Allergy and Infectious Diseases	http://www3.niaid.nih.gov/
National Institute of Health Policy	www.nihp.org

National Institute of Mental Health	www.nimh.nih.gov
National Institute on Alcohol Abuse and Alcoholism	www.niaaa.nih.gov
National Medical Association	www.nmanet.org
National Minority AIDS Council	www.nmac.org
National Minority Quality Forum	www.nmqf.org
National PACE Association	www.npaonline.org
National Partnership for Women and Families	www.nationalpartnership.org
National Patient Safety Foundation	www.npsf.org
National Quality Forum	www.qualityforum.org
National Senior Citizens Law Center	www.nsclc.org
National Vaccine Information Center	www.909shot.com
National Vaccine Program Office	www.hhs.gov/nvpo/
National Women's Health Information Center	www.4women.gov
National Women's Law Center	www.nwlc.org
Nemours Health and Prevention Services	www.nemours.org
New America Foundation	www.newamerica.net
NIHCM Foundation	www.nihcm.org
Office of Homeland Security	www.whitehouse.gov/homeland/
Office of the National Coordinator for Health Information Technology (ONC)	www.hhs.gov/healthit/
Office of the Surgeon General	www.surgeongeneral.gov
Open CRS	www.opencrs.com
Packard Foundation	www.packard.org
Pan American Health Organization	www.paho.org
Partners Healthcare	www.partners.org
Patient Safety Institute	www.ptsafety.org
Pharmaceutical Care Management Association	www.pcmanet.org
Pharmaceutical Research and Manufacturers of America (PhRMA)	www.phrma.org
Physicians for Human Rights	www.phrusa.org
Premier, Inc.	www.premierinc.com
Private Enterprise Research Center	www.tamu.edu/perc/
Project HOPE	www.projecthope.org
Public Health Informatics Institute	www.phii.org
Public Policy Institute, AARP	www.aarp.org/research/ppi
RAND Health	www.rand.org/research_areas/health/
Robert Wood Johnson Foundation	www.rwjf.org
Rollins School of Public Health, EmoryUniversity	www.sph.emory.edu
RTI International	www.rti.org
Rutgers Center for State Health Policy	www.cshp.rutgers.edu
SAMHSA's National Clearinghouse for Alcohol and Drug Information	http://ncadi.samhsa.gov
SAMHSA's National Mental Health Information Center	www.mentalhealth.samhsa.gov
The SCAN Foundation	www.thescanfoundation.org
Service Employees International Union	www.seiu.org
State Coverage Initiatives	www.statecoverage.net
Substance Abuse and Mental Health Service Administration (SAMHSA)	www.samhsa.gov
Technical Assistance Collaborative	www.tacinc.org
Thomson Reuters	www.medstat.com
Treatment Research Institute	www.tresearch.org
Trust for America's Health	www.healthyamericans.org

U.S. Army Medical Research Institute of Infectious Diseases	www.usamriid.army.mil
U.S. Pharmacopeia	www.usp.org
UND Center for Rural Health	www.med.und.nodak.edu/depts/rural/index.html
United Hospital Fund	www.uhfnyc.org
UnitedHealth Group	www.unitedhealthgroup.com
Univ. of Minnesota - Prime Institute	www.pharmacy.umn.edu/centers/prime/
Univ. of Texas School of Public Health	www.sph.uth.tmc.edu
University of Maryland Dept. of Women's Studies	www.womensstudies.umd.edu
University of Maryland School of Medicine Department of Epidemiology and Preventive Medicine	http://medschool.umaryland.edu/Epidemiology/
University of Pennsylvania School of Nursing	www.nursing.upenn.edu
Urban Institute	www.urban.org
U.S. Census Bureau	www.census.gov
U.S. Census Bureau, Health Insurance Data	www.census.gov/hhes/www/hlthins/hlthins.html
Vaccine Research Center, NIH	www.vrc.nih.gov
Vanderbilt Center for Better Health	www.mc.vanderbilt.edu/vcbh/
Veterans Health Administration	www.va.gov/health/index.asp
Voices for America's Children	www.childadvocacy.org
Wharton School of the University of Pennsylvania	www.wharton.upenn.edu
Wellpoint Health Networks, Inc.	www.wellpoint.com