

Health Care in the United States is not a complete failure. It is amazingly good at certain things, such as research and development of new treatments. However, there are many flaws in the system; lack of access, inefficiencies in delivery and expense. There are many issues to consider with reform, and during this unit meeting we will explore healthcare basics and their economical impact.

The Unit Meeting purpose is to educate ourselves about health care reform and universal coverage not only within our borders but beyond. We will be exploring the current state of health care in the US and in other advanced capitalist democracies – United Kingdom, Japan, Germany, Taiwan and Switzerland. A discussion of their system's benefits and drawbacks will take place. **Sick Around the World, Frontline Program** video will be presented at the unit meeting. In preparation, the following materials have been assembled.

LEAGUE POSITION

The League believes that quality, affordable health care should be available to all U.S. residents.

Other U.S. health care policy goals should include:

- The equitable distribution of services,
- Efficient and economical delivery of care,
- Advancement of medical research and technology,
- And a reasonable total national expenditure level of health care.

Furthermore, the League believes that all Americans should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care.

Through the decades of work in our communities, League members have learned that Americans believe that fairness and responsibility, as well as access, are important values for any health care system. We believe that health care reform can only succeed if it takes all these values into account.

BASIC HEALTH CARE SYSTEMS

There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.

But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems:

The Beveridge Model

This model was named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library.

Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.

Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style health care, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control.

The Bismarck Model

Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction.

Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model -- Germany has about 240 different funds -- tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides.

The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.

The National Health Insurance Model

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.

The single payer tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated. The classic NHI system is found in Canada, but some newly industrialized countries -- Taiwan and South Korea, for example -- have also adopted the NHI model.

The Out-of-Pocket Model

Only the developed, industrialized countries -- perhaps 40 of the world's 200 countries -- have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die. In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease. In the poor world, patients can sometimes scratch together enough money to pay a doctor bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care.

CURRENT US HEALTH CARE

These four models should be fairly easy for Americans to understand because we have elements of all of them in our fragmented national health care apparatus. When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany.

For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.

The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody. This is much simpler than the U.S. system; it's fairer and cheaper, too.

MEDICARE AND MEDICAID OVERVIEW

Interest in health reforms grew during the early twentieth century but these efforts were suspended with the United States entry into World War I. Though it was discussed, no health programs were included in the adopted version of the Social Security Act of 1935. The National Health Act of 1939, which would have created a compulsory health insurance program for almost all employees and their dependents in the country was fought vigorously by the American Medical Association and other interests and died in committee. Repeated failures over the next two decades to establish a comprehensive national health insurance plan, in large part because of fierce opposition by the AMA, led reformers to try for more limited plans covering the neediest groups. In 1948 President Harry S. Truman became the first sitting president to officially endorse national health insurance. But enactment failed to follow, in part because the initiative was caught up in a wave of anti-communist opposition. Congress took a small, but in retrospect, a most significant step, in 1950 when it created a grant program to provide federal matching funds to states for health care payments for individuals on welfare. In 1960, President John F. Kennedy made Medicare part of his national agenda.

On 31 July 1965, President Lyndon B. Johnson signed the Medicare and Medicaid Bill into law. The first part, Medicare, expanded the Social Security Act's old age pension program. Through wage deductions, employees would contribute to a Medicare trust fund. At retirement, those eligible for Social Security benefits would also receive coverage for hospital care, some surgical care, and nursing home reimbursements. The original law specified 120 days of hospital benefits and 120 days of nursing home follow up benefits. The Medicare program also included general revenue funds for hospital construction, diagnostic equipment purchase, and grants to teaching hospitals for medical education. A second part of the 1965 law, called Part B, covered visits to physicians. This option had to be selected by eligible individuals on retirement. If this option were chosen, deductions were made from the recipient's monthly Social Security checks. The third part of the bill, Medicaid, funded from general tax revenue, provided health care for the needy poor and others. Administered by the individual states, Medicaid covered a broad range of people, including welfare recipients, persons who were blind or disabled, and low income elderly citizens who did not qualify for Social Security or whose Medicare benefits had run out.

Changes in 1971 and 1974 instituted a review of standards and costs and tried to eliminate duplication of equipment and hospitals. Revisions in 1983 standardized charges for medical procedures. In the 1980s healthcare discussion turned to the long term needs of the elderly, coverage for medical catastrophes, and ways to preserve the Medicare system when the large baby boomer cohort of the population reached retirement age. Health maintenance organizations (HMOs), introduced by the private sector after being enabled by legislation passed by Congress in 1973 as a way to control rising costs, were subsequently included as an option for Medicare and Medicaid recipients. At the end of the century, debate focused on ways to cover the approximately forty-four million uninsured Americans and to provide reimbursement to Medicare recipients for expensive pharmaceuticals. In 2003, under intense pressure from the George W. Bush administration and the American Association of Retired Persons, Congress narrowly passed legislation giving older Americans limited prescription-drug benefits under Medicare beginning in 2006.

Medicare and Medicaid are known as entitlement programs for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. 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.

KEY HEALTH REFORM TERMS

During the unit meeting, an update on the current legislation will be presented. In preparation, the following glossary is intended to serve as a resource for understanding the concepts included in the current health reform proposals. It provides simple and straightforward definitions of key terms that are part of the health reform debate.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders.

Countercyclical: Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Disproportionate Share Hospital (DSH) Payments: Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Employer Pay-or-Play: An approach that would require 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.

Federal Employee Health Benefits Program (FEHBP): A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

Health Insurance Exchange/Connector: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Through HIPAA, individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operate in 34 states but vary by who is eligible, cost sharing requirements, availability of premium subsidies, and funding sources.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance.

Managed Care: A health 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.

Portability of Coverage: Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

Pre-existing Condition Exclusions: An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

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.

Primary Care Provider: A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.

Public Plan Option: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Purchasing Pool: Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs.

Risk Adjustment: The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

Single-Payer System: A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

Socialized Medicine: A health care system in which the government operates and administers health care facilities and employs health care professionals.

Uncompensated Care: A measure of the costs of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the federal government.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate. Single payer proposals would also provide universal coverage.

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