Healthcare **Communication** Review

**On Healthcare Relationships, Roles, and Resources**

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**** SPECIAL ISSUE ****

**Understanding & Managing HEALTH INSURANCE & THE COST OF CARE**

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## Health Insurance and the U.S. Healthcare System

**In the Beginning…**

It was not until the early 1900s that what we now call "health insurance" first became available to patients. It was started by the medical establishment in response to a need to attract the many patients who, unable to pay for medical care, were staying away from doctors and hospitals. Years earlier, a similar need to attract patients had led a number of doctors to enter into arrangements that loosely resembled some forms of health insurance.[1]

In the 1700s and early 1800s, high levels of competition and the self-sufficiency of Americans, most of whom lived in rural America, led many doctors to actively court patients. Some offered additional services. Some accepted an annual wage to provide care for a given family, or a plantation or the needy. That all began to change after the Industrial Revolution of the mid-1800s drew increasing numbers of people off their farms and into cities. For a variety of reasons, city living led these formerly independent people to become more reliant on doctors. This reliance, plus advances in medicine and technology, served to increase the value and cost of care.

While some doctors were paid by companies or member organizations to care for their constituents, most physicians' fees were paid directly by patients. As rising costs made it increasingly difficult for them to pay for care, more and more Americans stopped seeking it. In 1929, to fill their many empty hospital beds, Baylor University Hospital in Dallas, Texas offered local teachers the first health-insurance plan, as we know it today. For a fee of six dollars, individuals were entitled to three weeks of hospital care. This agreement was later extended and, before too long, other hospitals created similar programs.

In 1932 the American Hospital Association established guidelines for providing coverage of hospital services and Blue Cross was born. Encouraged by the success of Blue Cross, the American Medical Association (AMA), through its state medical societies, established Blue Shield – a non-profit plan that reimbursed patients for the cost of doctors' fees. When commercial insurers saw the profitability of such programs, they began to offer their own health insurance plans. During this same period, serious efforts to establish a national, compulsory health-insurance plan met strong resistance and failed. Health insurance remained in the private, mostly non-profit sectors.

Job-based insurance became the primary means by which people acquired coverage for their healthcare expenses. First, labor unions had been pressuring businesses to provide "benefits" for workers. Second, in 1954, businesses

See **System,** on pg. 3

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PO Box 661
Stone Ridge, NY 12484
Phone/fax 845-687-2328
www.healthcp.org

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***Healthcare Communication Review***
Written and Edited by
Judith A. Greenfield
judith@healthcp.org

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## *From the Editor*

For many, these are dire times. More than 15% of our non-elderly population (about 44 million people) are uninsured. Many more are underinsured, with estimates ranging from 40 to 70 million people. All are at increased risk not only of poor health but also of financial ruin. (As has been pointed out by a recent Harvard study, an investigation in five states showed that half of all bankruptcies in 2001 arose from medical costs or illness – even for people with health insurance.) In the meantime, those of us who have adequate health care coverage should enjoy the moment – because it may not last. With reports of decreasing numbers of employers providing health benefits for retirees and of increases in premiums paid by employees, accompanied by decreases in coverage, who's to say we'll not soon join the ranks of the un- and underinsured?

Why has this happened? What can be done about it? What *should* be done about it? Does the active patient have a role to play here? If so, what? And how? After all, how can average citizens ever fully understand this hugely complicated subject? How can they sort through the competing claims made about proposed solutions? For instance, should we rely on the marketplace and keep government out of it, as some claim; should we ask for single-payer universal coverage with the federal government being the payer; or will patchwork changes do?

And what about more immediate and practical concerns? How can patients get the coverage and the care they need now? To help in this regard, we offer the article "Finding Care for the Uninsured, Help for Insurance Problems." For help with understanding and managing healthcare bills and help in detecting any billing errors or under-payments by insurance companies, we offer the piece "Keeping Track of Care and Payments," along with a review of *Medical Bill Workbook*. And in "Health Insurance Q & A" we address two timely concerns.

The larger public-policy aspects of health insurance and costs of care remain important, however, for they will ultimately affect each American individually. We therefore offer articles to introduce readers to a major concept behind various solutions to the problems discussed herein, in the hope that it will help readers arrive at their own seriously considered answers.

In covering these larger, public-policy matters, we take a page from medical researchers who understand that the first step in finding cures for particular diseases or conditions is to understand as much as possible about them. In "Health Insurance and the U.S. Healthcare System" we present the history of health insurance and its effects on the structure of our healthcare system. The articles relating to cost of care, look at ways in which un- and underinsurance affect healthcare costs and, by 'following the money,' at who actually pays for all of this. The article "Insurance Reform: Key Questions" then identifies some proposals for fixing our system and presents questions readers might ask about each.

For those who will want to continue reading on the matters covered in this issue, we offer reviews of Paul Starr's Pulitzer-prize-winning book, *The Social Transformation of American Medicine* and Dr. Marcia Angell's recently released book, *The Truth About the Drug Companies*. As with all our issues, we hope this publication will help readers find their voices as active partners in healthcare.
Be Well. *Judith A. Greenfield*

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**System** *continued from pg. 1*

were granted federal tax-exempt status for payments of healthcare premiums. Because it became less costly for them to pay their workers in wages *and* benefits than by wages alone, they started contributing to health insurance premiums – in some cases paying the full costs. Finally, group insurance purchased by businesses was cheaper than insurance purchased by individuals. This had the effect of leaving the poor – many of whom were unemployed (though not all) and many whom were elderly – out in the cold.

In 1965, with the "war on poverty" and the establishment of Medicare and Medicaid, federal and state governments became healthcare insurers for people who were not in the military. With this added coverage for many of the previously uninsured, most Americans now had access to doctors and hospitals.

What made health insurance work so well, at this time, was that it did not interfere in the decisionmaking process. With payments going directly to patients – to reimburse them for out-of-pocket medical costs – they were allowed free choice of hospitals and doctors. It also left final decisions about treatments to doctors and patients, not insurers (third-party payers). That, however, led to its undoing.

***What made early forms of health insurance work so well was that it did not interfere in the decisionmaking process… That, however, led to its undoing.***

**Insurance: Once an Answer, Now a Problem**

Once again Americans are facing high costs of healthcare that are increasingly unaffordable. With more than 15% of our non-elderly population uninsured and many more underinsured, too many people are not getting the healthcare that they need. What happened? Health insurance was supposed to be the solution – to help people afford healthcare. Instead, in its original form of fee-for-service reimbursements, it turned out to be "…the central mechanism of medical inflation.[2]"

Fee-for-service reimbursement – with insurance companies reimbursing most of patients' out-of-pocket costs for *each covered service* they accessed – provided great incentives for patients, doctors and hospitals to use the system to their own advantage. As healthcare costs rose, patients simply sought more insurance coverage. Having coverage, they then acted on the questionable belief that, when it comes to healthcare services, more is better. Similarly, doctors and hospitals acted upon built-in incentives. In their case, extremely favorable terms of reimbursement, along with the knowledge that patients would not have to pay, encouraged them to raise rates of care in general *and* to provide more services. Also, because specialists and procedures performed in hospitals were reimbursed at higher rates, many more doctors chose to become specialists and to treat patients in hospitals – even when not necessary.

Feeling the pinch of rising costs, insurers raised the cost of premiums. In turn, patients and businesses also experienced increasing difficulties. In addition to facing higher premiums, businesses were now mandated to change their accounting procedures so as to indicate retiree health-insurance coverage as a liability. Things were tough all around. Something had to be done. And it was. Government, private insurers and businesses joined forces to contain costs.

**The Cost Containment Era**

Because the main objective was (and still is) to contain costs, private and public insurers have used a variety of means for reducing the amounts they would pay patients, hospitals and physicians for services rendered. While patients were asked to share more of the costs of care, most efforts focused on doctors and hospitals. These included 15-month freezes in prices in 1984 and 1986, as well as congressional enactments of laws that changed the formulas for calculating payments to physicians and hospitals.

These and other measures had many far-reaching effects. Where, before, physicians and hospitals had no involvement in securing reimbursements, now they did. Extra staff had to be hired for, and many hours spent on, dealing with insurance companies. With more money going out and less coming in, the need to survive led to a change in the structure of our healthcare system.

"Economies of scale" became the watchwords of survival. For instance, administrative costs borne by individual doctors are less for ten doctors in a group practice than it is for ten doctors in solo practices. The same holds true for hospitals. As a result of these cost-containment measures, then, physicians moved from solo to group practices. Similarly, many hospitals formed conglomerates through horizontal integration (mergers with one another) or

*See* **System**, *pg. 4*

**System,** *continued from pg. 3*

vertical integration (mergers with home care agencies, nursing homes and other different levels of care.) Perhaps more importantly, the health industry shifted from being mostly non-profit to being mostly for-profit institutions. Ambulatory diagnostic and surgical settings, established by physicians with the backing of venture capitalists, is but one example of this move into the for-profit health arena.

With other changes the boundaries of American medicine started to blur. Some insurers directly provided healthcare services (HMOs) and some businesses shifted to self-insurance. Not the least of all these changes, however, was the rising dominance, in the 1990s, of the managed care system. This tightly controlled system of care, restricting patients' choice of doctors and requiring them to get authorization to see specialists, inserted third-party payers into the decisionmaking process by requiring their approval for more expensive treatments.

***Despite limited successes, the costs of care and insurance premiums have continued to rise, leading all involved…to new directions in healthcare and insurance.***

And what about cost containment? The move to a managed-care system, with its restrictions on access to care and payments to doctors, did slow down the rise in healthcare costs. In the end, however, such strict controls were not tolerated by the public and, over the last few years, those controls eased. So did constraints on cost. While still contracting with doctors for reduced rates of care and requiring authorization for certain treatments, insurers are increasingly offering plans that allow patients to go to see doctor they want.[3]

In part because of this, the late 1990s saw an end to a slowdown of annual increases in costs of care and insurance premiums once again began to rise at alarming rates. [See **Insurance and Costs,** pg. 5]. Once again, the search for ways to survive and thrive has led to the emergence of new directions in healthcare and insurance. Frustrated by the need to schedule more patients each day to cover their costs – and the subsequent limitations of time to be spent with each patient – some doctors are setting up cash-only practices; some are charging access, or administrative, fees for "extra" services such as renewing prescriptions, responding to email messages; and others are shifting to "boutique" practices – making themselves available 24 hours per day, seven days a week to a greatly reduced number of patients who pay an annual fee of $2000 - $20,000 a year (in addition to healthcare insurance).[4]

At the same time, businesses are reducing or eliminating health benefits for workers. Many are no longer promising coverage for future retirees and most are asking workers to carry a greater share of the costs of premiums.[5] They are also beginning to offer their employees the option of Consumer Driven Health Plans – a new form of coverage that some claim will replace managed care. These offer lower premium payments in exchange for deductibles of up to $10,000 per family. [See **Insurance Reform**, pg. 6]

The effect of all this on workers is great. For some, it may mean not changing jobs when they want to – even though a new job might offer a higher salary. This can be the case even though the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 to allow workers to easily move from one job to another without losing health insurance coverage and without suffering long-term consequences for pre-existing medical conditions. Why? Because not all coverage is created equal and weaker financial protections in the health benefits that come with a new job may keep some workers from leaving their old one.[6] Then there are the increasing number of workers who, called upon to pay greater shares of higher premiums (or lower premiums but higher deductibles) decide not to sign up for health insurance. When adding them to the many workers who are not given the opportunity for job-based coverage and to the un-employed poor, we begin to understand the rising numbers of un- and under-insured Americans.□

[1] Unless otherwise noted, the contents of this article are drawn from Paul Starr, *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry* (NY: Basic Books, 1982).

[2] See note 1, Starr, 385.

[3] See Tracking Report # 5 at www.hschange.org

[4] See *Medical Economics* web polls at www.memag.com and www.ama-assn.org/amednews: Markian Hawryluk, "Boutique medicine may run afoul of Medicare rules" (April 8, 2002).

[5] See Tracking Report No. 9 at www.hschange.org; Kaiser/Hewitt Retiree Health Benefits Study at www.kff.org; and Report # he97122 at www.gao.gov/archive/1997.

[6] Follow *What's New* links to "Nichols Testifies About 10 Myths of the Uninsured" (March 9. 2004) at www.hschange.org.

## Insurance and Costs

There are many reasons why, nationwide, health spending continues to climb at a rate faster than the overall economy.[1] Not the least of these is health insurance. Consider this. The establishment of health insurance enabled people to access care when they otherwise might not have been able to afford it. It worked – perhaps too well because, relieved of the burden to pay, patients' demands and favorable reimbursements drove costs up. The subsequent cost containment measures had limited success. Costs continued to rise – sometimes slower, sometimes faster but always more than the overall economy.[2]

Costs of insurance premiums also continued to rise – sometimes slower, sometimes faster. Today, however, large numbers of the insured are paying more for less coverage. Many of these might be classified as *underinsured* – generally defined as having annual out-of-pocket costs that exceed 10% of their annual income or, according to the Center for Disease Control, as failing to see a doctor because of cost concerns.[3] At the same time, the slow but steady decline in jobs that offer health benefits along with increasingly unaffordable premiums are leaving great numbers of people *uninsured*.

**Just as insurance has played a role in rising costs of care, so too has uninsurance and underinsurance.**

### Costs of Un- & Underinsurance

It is important to note, however, that just as insurance has played a role in rising costs of care, so too has un- and underinsurance. In particular, a practice known as *cost shifting* contributes to increases in health spending. That is, financial losses from the treatment of patients with no or low-paying insurance (often public insurance) are made up for by charging more for treatment of patients with higher-paying insurance (usually private insurance). Cost shifting often leads private insurers to raise the price of premiums in order to cover these shifted charges.[4] Similarly, when the uninsured seek care from hospitals and clinics, some of the cost of that care is shifted to the public – with federal, state and local governments chipping in about $30 billion a year.[5]

### Other Costs of Uninsurance

In a series of six reports published between October 2001 and January 2004, the Institute of Medicine (IOM) details the findings of their Committee on the Consequences of Uninsurance – namely, that the costs of uninsurance begin on a personal level and extend to the community and the nation.[6] In "Care Without Coverage" (May 2002), they state that the uninsured often delay getting care and, as a result, are more likely to be sicker and die sooner. In "Health Insurance is a Family Matter" (September 2002), they report that about half of all personal bankruptcy findings are sparked by medical bills. (A recently published study confirmed this, with the added information that having health insurance was not a safeguard against personal bankruptcy due to medical expenses.[7])

As outlined in their fourth report, "Shared Destiny" (March 2003), health facilities and professionals in communities with a large uninsured population, are often forced to cut back on services – losing many levels of service, including emergency and high-tech care. In "Hidden Costs, Value Lost" (June 2003), they go on to say that poorer health and early deaths of the uninsured jeopardizes the ability of communities to provide healthcare services to their entire population. This lost productivity, they state, diminishes both the economic vitality and productivity of our nation. Their conclusion is this: *It is both mistaken and dangerous to assume that the persistence of a sizable uninsured population in the United States harms only those who are uninsured.*[8]□

**It is both mistaken and dangerous to assume that the persistence of a sizable uninsured population in the United States harms only those who are uninsured.**

Institute of Medicine

[1] See Tracking Reports and Issue Briefs at www.hschange.org, the Center for Studying Health System Change; See "The Factors Fueling Rising Healthcare Costs" found at the site of PriceWaterhouseCoopers, www.pwc.com. Click on publications, then healthcare, then enter "Rising Costs" in search box and follow links to the article.

[2] Enter "Snapshot" in search box and follow links to "Snapshot Health Care Costs 101" (2004) at www.chcf.org.

[3] "State-Specific Prevalence Estimates of Uninsured and Underinsured Persons – Behavioral Risk Factor Surveillance System – 1995," *MMWR* 47(3): (January 30, 1998) at www.cdc.gov/mmwr. Click on Health Topics A-Z and enter "underinsured" in search box.

[4] See "Frequently Asked Questions" at www.fepblue.org.

[5] See "Health Care Costs and Financing," November/December 1995 at www.ahrq.gov/research; also follow links to "Hidden Costs, Value Lost" (June 2003) at www.iom.edu/reports.

[6] Follow links to individual reports at www.iom.edu/reports.asp.

[7] See David U. Himmelstein et al. "Illness and Injury as Contributors to Bankruptcy" *Health Affairs* Web Exclusive (February 2, 2005) at www.healthaffairs.org.

[8] See note 5, IOM web site, "Shared Destiny" (March 6, 2003), 7.

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## Healthcare Costs: Who Really Pays?

It's generally agreed that the costs of care are shared. With job-based insurance, businesses and their employees share the costs of premiums. Private insurance companies and patients share the costs of particular healthcare services. Governments share costs of care for the elderly, the poor, and the uninsured. The share of costs borne by patients, then, would seem to be limited to their share of premium costs and what they have to pay "out-of-pocket" for actual medical expenditures. But is this really the case? Len Nichols, an economist and Vice President of the Center for Studying Health System Change, believes not.[1] Appearing before a congressional hearing on the uninsured, Dr. Nichols stated that most employers do not pay for the health benefits they offer. Instead, he claims, economists generally agree that most workers "…end up paying for health insurance in the form of lower wages."

***…most, if not all, of our nations' healthcare spending can be traced back to individual households – to you!***

Looking at it another way, working families ultimately bare the burden of healthcare costs – for themselves and others. In a 1991 *USA Today* article Kevin Anderson showed how most, if not all, of our nations' spending on healthcare can be traced back to individual households – to you.[2] Based on interviews with many experts and raw data from the government, he was able to chart the path of dollars that families spent on healthcare in 1990. Out of a calculated share of national health spending ($6,750 per family), $558 went to pay for premiums and $1,515 for medical expenses.

But household spending on healthcare did not end there. The balance, $4,677, was paid through the purchase of goods and services and taxes to all levels of government. That is, healthcare costs built into prices charged for products were used by businesses to pay both their share of insurance premiums and a variety of government taxes which, in turn, were used to pay a share of health spending. Similarly, portions of the federal, state and local taxes paid by families were earmarked for healthcare – premium payments to private insurers for government employees, Medicare, Medicaid, state aid to hospitals, military healthcare, public health and so on.

While today's dollar figures have changed since 1990 (who wouldn't love to be paying just $558 a year for health insurance premiums!) the methods of paying for our national health expenditures has not. Many of us, however, don't think of these hidden costs. Add to that the fact that we are shielded from the actual costs of healthcare, (outside of deductibles we "only pay" co-payments), and many of us feel like we are paying much less than we actually do. As a result, the financial consequences of the "more-is-better" syndrome – one reason why national health spending is soaring – is not very obvious.□

[1] Follow 'What's New' listings to "Nichols Testifies About 10 Myths of the Uninsured," March 9, 2004 at www.hschange.org.

[2] Kevin Anderson, "How you pay for your share of health care," *USA Today* (May 6, 1991): 3B.

## Insurance Reform: Key Questions

*…no one in their right mind would invent the American health care system if they actually had a concern about health care. It evolved and we're in a position of re-inventing it.*

Jeffrey A. Romoff, President, University of Pittsburgh Medical Center Health System[1]

Wait! How can someone say that no right-minded person would invent the American healthcare system when we are repeatedly told that ours is the best in the world? One explanation may be this. If we look at our physicians, hospitals and medical technology, we have a strong argument for ours being the world's best system. However, if our system is judged by its effectiveness in keeping people healthy or restoring them to health, the argument becomes much weaker. Indeed, visitors to **www.nationmaster.com/cat/health**[2] will find health statistics that show we far exceed other developed countries in health spending, but not in health outcomes. The United States, for instance, compares poorly in such categories as infant mortality rates, low-birth weight, years of living in ill health and life expectancy.

If we have the best doctors, health facilities and medical technology, why don't we have the best results? Whatever else might explain this contradiction, one reason must surely be that not everyone is able to access all that we have to offer, or to access it to its fullest. Insurance is supposed to help people access care. Instead, its much-needed cost-containment measures have not only been less than successful in the long run, they have also changed the structure of our healthcare system; injected third-party payers into the process of making treatment decisions; greatly increased the administrative costs of physicians and facilities and; ultimately, contributed to a complex, fragmented system in which too many people are deprived of needed care – a system which, perhaps, no one in his or her right might would invent. In this regard, then, re-inventing our healthcare system, means re-inventing insurance.

See **Reform**, pg. 7

**Reform**, *continued from pg. 6*

Some change has already begun – though in the form of a new type of health plan that keeps the current structure of our system, so can't fully address problems such as cost shifting and the uninsured. Consumer Driven Health Plans set up spending accounts. Employers deposit up to $2000 per family in it, to be used to pay for medical care. If used up, families must pay all expenses out-of-pocket (up to $8,000 more per family) – thus encouraging patients to be more selective in their use of medical services. Once the deductible is reached, insurers pay the full costs of any additional medical expenses. Any monies left in the spending account may be rolled over to the next year. Because these plans are equally available to employees of large and small businesses as well as to the self-employed, they are expected to reduce the number of uninsured.

One such account, the soon-to-be offered Health Savings Account (HSA) is similar to others of its class, with its lower premiums, but are owned by enrollees and go with them from job to job. These plans will be good for many people, but few families can afford up to $8000 a year in out-of-pocket expenses. Does that mean mostly younger, healthier families will sign up for HSAs, leaving older, sicker families with traditional policies? Since insurers need healthy enrollees to help cover the costs of sick enrollees and still make a profit, what will happen to coverage for people with more medical expenses?

**Proposals for Re-Inventing Insurance**

Proposals for insurance reform include the call for a free-market system that is not subject to any interference from the government. The claim is that competition between private, for-profit businesses – free from government mandates and regulations – would encourage innovation and lead to lower costs. Another calls for a universal, single-payer system – perhaps modeled after Canada's healthcare system. The claim here is that, with the government as the payer, not only would everyone have access to healthcare services, but savings in administration costs and covering the costs of the uninsured would also provide enough money to pay for it all. Still others call for new approaches to expanding coverage to currently uninsured people (employer mandates, tax credits, vouchers and so on) while maintaining the structure of our current system. One such proposal suggests the use of such strategies for a transitional approach to universal healthcare. [For more details, see sources on pg. 8.]

**Key Questions**

Answers to deeply philosophical questions underlie arguments in support of one proposal over another. Each of us, knowingly or not, will ask and answer them when deciding which reform measure we prefer. Do the interests of the individual outweigh the need of society to protect the health of all its citizens? Or, do the needs of society, in this particular case, outweigh the interests of individuals? These questions often appear in the form of: Who should have primary responsibility for healthcare insurance – the private sector (business), public sector (government), or both, as we do now?

Important practical questions relate to how well each solution will address key issues of access, cost and quality. These may include: How effective will each be in addressing the problems of uninsurance, underinsurance and hidden costs? In looking at the polar opposite reform solutions of free-market and single-payer systems, we can see that there are good arguments to support each. Yet serious questions abound. What protections will patients have in a free-market without mandates and regulations? Mandates and regulations can be double-edged swords, working for or against individual patients, depending upon their circumstances, but should access to healthcare be solely determined by businesses whose ultimate goal is that of maximizing profits?

Such a goal is acceptable, even desirable, perhaps, in the for-profit world. So much so that representatives of the commercial health insurance industry have had no qualms about revealing their motivations for making decisions that may negatively affect patients. Recently, for instance, one spokesman for the industry reported that the doubling of his company's profits were achieved, in part, by trimming its membership rolls of the "least profitable" (sicker) members.[3] Similarly, in a 1996 *60 Minutes* report, another spokesman said: "…insurance is a business…it has social functions but it is not social welfare. Governments do social welfare. And insurance is a business, just like the corner delicatessen or the car dealership…"[4]

And what about a single payer system? Critics call this socialized medicine. Proponents say not. What does "socialized medicine" mean? What will a close look at Canada's system reveal? How much of the negative press about it is on target? How much is not? For instance: Who actually makes treatment decisions under the Canadian system? Who and what are covered? How do they pay for it? How would we pay for it? Could we contain costs differently than Canada, which uses an approach that results in waiting lists for treatment? What do Canadians really think about their system? And, how do doctors and hospitals, residents and patients, fare within it? The point is, accurate information, should play a large role when deciding which solution is preferred.

See **Reform**, pg. 8

**Reform,** *continued from pg. 7*

**A Fact of Life**

It is also a fact of life that our decisions often hinge on our experiences and our positions in life. Unfortunately, we can't know with great certainty whether those positions will remain the same or change dramatically. Deciding which solution we prefer, then, may be helped by taking a page from the book of John Rawls – a noted philosopher who suggested that a society's system of justice should be created by people who sit behind a "veil of ignorance." That is, people who make decisions for society and don't know what their own positions in that society are, are more likely to create a system that is fair to all. Similarly, in deciding what direction you want insurance reform to take, you might ask: what will be fair to me now and, if my position in life changes, years from now as well?

**A National Debate**

With the establishment of a Citizens' Health Care Working Group, in March 2005, Americans will have the rare opportunity to participate in a national debate on the subject of insurance reform. The Working Group – representing members of the general public, business, labor, healthcare delivery and financing communities – is charged with the task of providing for a nationwide public debate on how to improve our healthcare system so that it will allow each and every American access to affordable, quality healthcare. As part of this process, and after hearings have been held, the Working Group will hold community meetings throughout the United States. Through a variety of means, including the Internet, its preliminary recommendations will then be made available to the public for review and comment.[6]

Some see this as a back-door move towards universal care. Others see it as a narrowly focused effort designed to find different ways of maintaining our current system. As demonstrated by the 911 Commission, however, the fact remains that the public can influence this debate and outcome. It will be about one year before the community meetings begin. Readers can use that time to do their own research so that their participation in this public process can be an informed one.□

[1] "The costs of health care: How much and who pays?" *University Times* (University of Pittsburgh) 35(9): 4 (January 9, 2003).

[2] For comparisons of developed countries, access statistics using the "make your own graph" section at the top of the page.

[3] Robert Kazel, "Managed care profits up, optimism for 2005 strong," *AMNews* (Feb 28, 2005) found at www.amednews.com.

[4] See transcript of Steve Kroft, "Do You Really Want to Know," CBS News' *60 Minutes* (April 21, 1996): 8.

[5] See note 1.

[6] See Health Care That Works For All Americans Act by entering "pl108" in keyword search box at www.gao.org

## Information Resources

**FREE-MARKET COMPETITION**

The Galen Institute
**www.galen.org**
And
The Libertarian Party
**www.lp.org**
See
"Libertarian Solutions: There are free market answers to America's health care crisis"
Enter "solutions" in search box and scroll down for link.

**TRANSITIONAL UNIVERSAL COVERAGE**

**www.centrists.org**
Click on Universal Coverage

**SINGLE-PAYER, UNIVERSAL COVERAGE, ALA CANADA**

Third World Traveler
**www.thirdworldtraveler.com**
Scroll way down on home page to "Health Watch", Click, then scroll down to "O Canada, Health Care Myths from the Great White North"

(U.S) Government Accountability Office
**www.gao.gov**
See "Canadian Health Insurance: Lessons for the United States"
Enter "HRD-91-90" in keyword or Report # search box, Click on article link.

**CONSUMER DRIVEN HEALTH PLANS**

The Galen Institute (see above)
And
American Federation of State, County and Municipal Employees, AFL-CIO
**www.afscme.org**
Click on Search (at top) then enter "CDHP"
Click on link to "…Fact Sheet, Consumer…"

**STATE INITITIATIVES, UNIVERSAL COVERAGE**

Vermont Health Care for All
**www.vthca.org**

Dirigo Health
**www.dirigohealth.maine.gov**

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# Finding Care for the Uninsured, Help for Insurance Problems

**Finding Care: Safety Nets**

Uninsured, non-elderly individuals and families not eligible for government safety net systems such as Medicaid and State Children's Health Insurance Programs (SCHIP), often find their way to hospital emergency rooms – after their health problems have become quite serious. While many emergency rooms are part of the safety net services available throughout the country other, more efficient, means of providing care for the uninsured are available. Throughout the country, a number of clinics and hospitals (public, private not-for-profit and teaching hospitals) as well as a variety of health centers provide safety net services for the uninsured. Physicians' sometimes provide safety net care as well, for their patients who lose health insurance. The key is to let doctors know if your situation changes and ask if they can help. While the loss of funding has limited offerings of safety net services, they do still exist. Not every community has them, however, nor is there a standard for the nature of care each will provide. Chances are, though, that one can be found not too far away.

One place to start looking for needed care, is with your primary care physicians. If they are not in a position to help you (you may need care other than that which they can give), they might be able to direct you to a local clinic or hospital that will provide the care you need. The Bureau of Primary Health Care, a branch of the (U.S.) Department of Health and Human Services also maintains a web site, **www.ask.hrsa.gov/pc**, where people can search for the safety net providers nearest them and find out what services they provide. If nothing is found by entering a zip code or city name, search again, listing just your state. You may find something a few towns over. Remember, libraries provide access to the Internet and librarians are there to help access information.

***Do you need dental, mental health, primary or specialty care? To see if these and other free or low-cost healthcare services are available in your area, visit the Bureau of Primary Health Care at www.ask.hrsa.gov/pc.***

**Finding Help for Insurance Problems**

Do you need to find insurance, or find ways to keep it? Do you think you need to appeal an insurance denial? Do you need help with medical debt? There are many health assistance programs throughout the nation that help people with these and other insurance problems. To find these programs contact local or state health departments, Area Agencies for the Aging, Departments of Social Services, or other local public or private human service agencies. Some of the programs in various states can also be found by visiting **www.healthassistancepartnership.org**. Once there, click on "Program Locator."

Access to Health Insurance, Resources for Care (AHIRC), started by the Actor's Fund of America to assist entertainers, has been expanded to provide resource information for the general public. Visitors to **www.ahirc.org** can find state-specific information regarding insurance, rights and protections, complaints and appeals, dealing with medical debt and more.

The Patient Advocate Foundation (800-532-5274) offers case managers who will help patients find local, state and federal programs appropriate for their individual needs. Visitors to their site, **www.patientadvocate.org**, after clicking on "Resources," will also find resources for patients in need of insurance, dealing with job discrimination; assistance with debt crises; guides to managed care and the appeals process; and a state-by-state directory of financial resources for a variety of needs, including health care. Patients in need of co-pay assistance may also find help by calling them, toll-free, at 866-512-3861. Assistance is available to patients with breast, lung, or prostate cancer, or who have macular degeneration, and meet financial eligibility requirements.

Medicare beneficiaries and their families who prefer face-to-face assistance, however, can turn to their State Health Insurance Assistance Program (SHIP). Here, trained counselors provide free assistance regarding Medicare, Medicaid and Medigap policies – including health plan options, long-term care insurance, claims and billing problems, health insurance benefit information and public benefit options for low-income individuals. To find your state's SHIP call your local Area Agency for the Aging; or contact the Centers for Medicare and Medicaid Services (CMS) by calling 800-Medicare or by visiting their web site's directory page at **www.cms.gov/contacts**.

# Keeping Track of Care and Payments

Given the complexity of health insurance, with its deductibles, co-pays, services covered and percentage payments for covered services, it's hard to keep track of monies that are paid, owed and by whom. If an individual or family has two health insurance plans, such as Medicare and a private Medigap policy, it can be even more confusing. For that reason, Leo Notari, a counselor for the New York State Health Insurance and Information Counseling Assistance Program (HIICAP)*, recommends that patients keep a record of their medical expenses (care, charges and payments). To help with this, he drafted a **chart**, which may be copied and used by readers – as is or adapted as needed. Keeping track, in this or some other manner, can go a long way toward helping both patients and the counselors they might turn to for assistance. The following glossary explains the headings in his chart.

**GLOSSARY**

(For Medical Expense Record on page 11)

**PROVIDER**

| | |
|---|---|
| Date of Service | Date the service was provided by provider |
| Provider | Provider's Name |
| Acc. Y/N | Does this provider accept Medicare Assignment |
| Amt. Billed | The amount the provider billed to Medicare |

**MEDICARE**

| | |
|---|---|
| Amt. Appr. | The amount Medicare approved for the service provided |
| Prov. | The amount Medicare paid the provider |
| Detbl. | The amount Medicare applied to your deductible |
| Me | The amount Medicare paid to you |

**MEDIGAP/SUPPLEMENTAL**

| | |
|---|---|
| Date Sent | The date the Medicare Summary Notice (MSN) was sent to the secondary insurer |
| Prov. | The amount the secondary insurer paid to the professional |
| Detbl. | The amount the secondary insurer applied to their deductible |
| Me | The amount the secondary insurer paid to me |

**INSURED**

| | |
|---|---|
| Paid/Date | The amount and date the insurer paid the provider |
| Owes | The amount the insured owes the provider after Medicare and the Secondary insurer have met their responsibilities |
| Comp. | Checked or dated when the provider has received all the money due them and payment is completed |

* Note: HIICAP is New York State's name for its SHIP program.

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# Health Insurance Q & A

***What Should I know about Health Insurance Scams?***

The first thing you should know is that an increasing number of small businesses and individuals have been targeted by bogus health insurance offerings. While claims may be paid at first, these fake companies eventually delay, refuse and then stop paying – leaving patients, self-funding employers, and healthcare professionals holding the bag – some with very heavy debt burdens. In fact, an investigation by the (US) Government Accountability Organization found that, for the three-year period of 2000 – 2002, *at least* $252 million dollars of claims went unpaid as a result of these scams.[1]

Bogus plans often offer coverage regardless of pre-existing conditions. They explain their low premiums by claiming that they are a type of organization that is exempt from federal and state regulations – perhaps an association, such as a union, or a professional employer organization that administers a company's self-funded benefits. In some instances, they enlist unsuspecting insurance agents to help market these plans, giving themselves an appearance of legitimacy.

The second thing you should know is that you must be especially careful when considering any plan that seems too good to be true. Investigate. The National Association of Insurance Commissioners (NAIC) urges people to make sure they are dealing with reputable agents; asking for the company's name and address; and checking the benefits booklet. If coverage is described only as "stop-loss" insurance, or a "union" plan is not offered through the union itself, contact the state insurance department. NAIC's "Consumer Alert: Protecting Yourself Against Illegal Health Plans" may be found at their web site, **www.naic.org**. Click 'Consumer Information Source' and follow links to this publication. Or call (816) 842-3600.

Other sources of information include a fact sheet for small businesses on protecting employees. It can be found at **www.dol.gov/ebsa**. Click 'Focus on Health Care Fraud.' Also, the Colorado Attorney General's Office offers purchasing tips for Discount Plans which, though neither illegal nor subject to regulations, are not substitutes for health insurance and may be problematic. Visit their site at **www.dora.state.co.us/insurance** and enter "Discount Health Plans" in the search box. If no information is available, even after taking these steps, think long and hard before signing up. □

[1] To learn more, visit www.gao.gov and enter "04-312" in the report number search box.

***What can I do when a doctor tells me that he has nothing to do with Medicare and will not submit a claim – and I've already paid in full for, and received, the treatment?***

There are two circumstances under which doctors treating Medicare beneficiaries may ask patients to pay in full before services are provided. One is when doctors accept Medicare's limiting charge of no more than 115% of its approved amount for particular services. In this case, doctors MUST submit claims to Medicare and may not charge patients for doing so. The other is where doctors have "opted out" of Medicare. In this case, doctors MAY NOT submit claims and, because neither Medicare nor Medigap policies will pay for services provided by them, there are no limits on what patients can be charged.

Frustrations with Medicare have led some doctors to stop taking new Medicare patients. Others have gone even further, by "opting out." Once they have opted out, physicians are excluded from Medicare for a period of two years. During this time, except for emergency or urgent care, patients MUST be told, *beforehand*, that they will have to pay for everything because Medicare will not pay anything. Patients must also be told why this is the case. To do this, doctors are required to use private contracts when providing services that are normally covered by Medicare.[1] Such contracts must also include statements that Medicare limits on payments do not apply in this case; that the patient agrees not to submit a claim or ask the doctor to submit one; and that the patient understands that he or she can get these services from a doctor who has not opted out. The contract's print must also be easily readable and patients must be given a copy.

If you are asked to pay in full and have *not* been given a contract, double check to make sure that Medicare will reimburse you by asking doctors beforehand if Medicare will cover the services provided by them. Carefully read anything you are asked to sign and ask questions if you don't understand the document. If you are given a private contract, consider whether you want to find another doctor. Information about getting care from doctors who have opted out can be found on page 34 of the *Medicare & You 2005* Manual. ***If you had not been asked to sign a contract, had paid-in-full before the service was provided, and then found that the doctor has opted out of Medicare, the doctor is required to return your money to you.*** If you have questions about the specifics of your particular situation, contact your local or state SHIP (see page 9).□

[1] See Steven M. Harris, "Contracts required for Medicare opt-out," *AMNews* (Dec. 9, 2002) at www.amednews.com.

## BOOK REVIEWS

### *The Social Transformation of American Medicine*

By Paul Starr • Basic Books • $26

**Reviewed by Margaret L. Gagnon, RN, MS, CNS**

As you read this book, it is evident that there is a cyclical nature to life and that some of the answers for the problems of today are inevitably steeped in the past. It is an historic and chronological work that speaks to the evolution of the complex American healthcare system. We see how the fight for power and control of the medical profession; the territorial battles from the public health domain; the birth and evolution of the now complex hospital systems; unionization with its profound effect on benefit packages; Federal and State attempts to control health care cost through regulations and rate setting; and the outgrowth of the health insurance industry all inter-twine to create the health care system we know today.

The role of the physician, for example, was not always clear and the reader is left with the sense of their struggles – to define who they were, to define their role in a society that itself was just evolving, for competence and authority – struggles that were impacted at each step by the economic and political structures of the time. With the reform of medical training; the maturing of the AMA; advances in science and changes in the social structure that placed a value on specialized knowledge, a new order of urban life and industrialization contributed to a marked change in physicians' economic power, higher incomes and enhanced social status.

Hospitals underwent similar changes. The earliest ones were places of filth and death that served the poor, the feeble and the sick. With their later redefinition as institutions of medical science, came an increased concern for cleanliness and ventilation; a growing emphasis on surgery and the treatment of acute illness; and a change in the population that they served. Informal control was brought about by the growth of medical specialization and hospitals. The need for referrals and hospitals created a shift within the medical profession from dependence on client relationships to dependence on colleagues.

Although I did not find this book an easy read, it provides valuable insights on how interactions of the medical profession, community health care, hospital systems, and the rise of the health insurance conglomerates are closely entangled with and impacted by the social, political and economic evolution of a society.

*Margaret Gagnon is co-founder of the Rose Women's Care Service Community Resource Center, in Highland, NY. She can be reached at RWCSCRS@aol.com.*

### *The Truth About the Drug Companies: How They Deceive Us and What to Do About it*

By Marcia Angell, MD • Random House • $24.95

It's hard to read this book and not begin to feel that the pharmaceutical industry (big pharma) is one of our worst nightmares come true. Besides the nightmare that we are all aware of – excessively high prices of prescription drugs – Dr. Angell, shows how big pharma has thus far protected itself against price controls in America by successfully inserting itself into the federal government's public policy process; by gaining formidable control of clinical drug trials and medical education with respect to its drugs; and by luring the general public into pressuring doctors to prescribe medicines that they may not need or may be no different from ones they are already taking. In response to the increasing numbers of state governments, which are defying federal law and taking matters into their own hands when purchasing prescription drugs, big pharma is now trying to influence state policy making as well.

What makes all of this especially nightmarish – if anything could – is that it is very hard to dismiss the author's charges as being unnecessarily alarming. Now at Harvard Medical School, this former editor of the *New England Journal of Medicine*, documents her charges as she peels away, one by one, the many complicated layers of big pharma's claims and actions. Readers can easily verify her statements – many of which are drawn from company representatives themselves, federal legislators, and members of the scientific communities.

From its pages, we learn about "me-too" drugs – virtually the same versions of currently existing drugs that are classified by the FDA as being no better than what is already on the market. We learn that these drugs, not truly innovative drugs, dominate the FDA approval list each year. We learn that clinical trials of these more profitable drugs usually compare the new drugs to placebos, not to drugs currently being used for the same purpose. We learn that some companies, to increase capacity for making me-too drugs have, at times, stopped making other, vital drugs – including important childhood vaccines, flu and pneumonia vaccines for adults, an injectable drug for cardiac resuscitation and some anesthetics.

In clear and simple terms, Dr. Angell shows us all this and more, ending with suggestions for improving our system (such as requiring that me-too drug trials compare the new drugs with equivalent doses of current drugs). She also suggests questions that patients might ask when doctors prescribe drugs for them. Because we know that an educated public can make a difference, on both personal and public policy levels, this book is a must read!

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  **April 2005 Question: What do you do if you disagree with your doctor about treatment for your condition?**

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**Promoting Health Partnerships**

**BOOK REVIEW**

***Medical Bill Workbook: Inside the Medical Billing Maze***
***A Patient's Guide to Detecting Medical Billing Errors and Underpayments by Insurance Companies***
By Pat Palmer and Nora Johnson • Medical Billing Advocates of America • $19.95

Given the complexity of our healthcare system, it may not surprise readers to learn that errors in medical billing and in third-party payments do occur. Billing errors often fall in the category of overcharges. The effect of these errors, claim the authors, extend beyond the financial and emotional stress experienced by individual patients. They contribute to our current crisis in healthcare spending. Individuals who pay attention to their medical bills can find those errors, get them corrected and, by doing so, help society as well as themselves. Here is where the workbook comes in. It is designed to help people find errors in billing and/or in insurance payments and is especially written for those who have no idea how to tackle such a task. In fact, Nora Johnson tells us, before she learned how to find and get billing errors corrected, she had never even been able to balance her own checkbook. Unending medical bills ultimately led her to Pat Palmer and the development of these new skills.

With clearly written step-by-step instructions, sample forms and sample cases, the authors guide readers through the process of reviewing medical bills for errors and insurers' Explanation of Benefits (EOB) documents for underpayments. Its chapters tell would-be billing advocates (whether for themselves or others) how to organize paperwork; how to order materials (for example: billing and insurance statements); how to log and analyze both medical bills and EOBs; and how to figure out if there is a need to do one of two more detailed reviews of hospital bills and, if so, how to do it. Having found errors, the book provides tips for negotiating their correction, beginning with responses, to challenges of bills, that state there are no billing rules and regulations that must be followed when billing privately insured patients (as opposed to publicly insured Medicaid and Medicare patients). Whatever form of insurance readers have, however, the chapter on negotiation provides sample letters for disputing a bill and walks readers through best to worst-case responses to that disputation. The book ends with resources, forms and a glossary of terms. To order, call 540-387-5870 or visit **www.billingadvocates.com**.

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