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Subject Area - Health

Cost, Efficiency, Choice and Equity in the United States Health Care System

Introduction

While excellent medical care is available in the United States, health care economics and the service delivery system present many challenges for the consumer and practitioner alike. This paper addresses four dimensions that are pivotal to the successes and failures of the system: cost, efficiency, choice and equity. The interplay of these dimensions across the canvas of health care options defines a system in flux, policymakers seeking a fair balance, and a nation in need of quality, affordable, accessible care.

How do Americans pay for health care?

The cost of health care in the U.S. is the highest in the world today. A higher percentage of national income, and more per capita, is spent on medical care by the United States than by any of the twenty-eight other country members of the Organization for Economic Cooperation and Development (OECD). The United States spent $4,178 per capita on health care in 1998, more than twice the OECD median of $1,783, and far more than its closest competitor, Switzerland ($2,794). U.S. health care spending as a percentage of gross domestic product (GDP), 13.6 percent in 1998, also exceeded the next most expensive health care systems, in Germany (10.6 percent) and Switzerland (10.4 percent) However, the U.S. government finances a smaller portion of health-care spending than does any OECD country except Korea (Friedman, 2001; Hilsenrath et al., 2004).

Being without medical insurance is synonymous with a lack of access to medical care. In the absence of a coherent, all-encompassing national health policy, such as universal coverage, Americans, under the age of 65 and above the low-income mark, face the necessity of obtaining some sort of private health insurance.

However, more than forty-two million Americans (15.5 percent) were not insured in 1999 (Bureau of Labor Education at the University of Maine, 2001). Most of the uninsured have no employer-provided health care options and are unable or unwilling to bear the cost for the few types of plans available to them. If ineligible for government assistance, the uninsured have little choice but to wait until their health concerns justify emergency room treatment, an extremely costly option for hospitals. In fact, these emergency facilities may turn patients away unless their conditions are deemed to be medical emergencies.

Of those who are insured, some can afford to pay, while others are covered by their employers for at least a portion of the cost. Employer-provided health care coverage, once an expected benefit, is becoming less common in the contemporary American workplace. Also, over the years, the array of services covered has become more limited, while the cost of insurance has risen. Rather like a black hole, the insurance industry, and the medical establishment in general, appear to suck in more resources while emitting less output.

What are the private plan options?

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Cost, efficiency, freedom of choice and equity vary across the assortment of private health care insurance alternatives. The following includes a brief description of each type of plan (derived, in part, from Levchuk et al., 2000), and thoughts on the balance of these dimensions across alternatives.

The traditional fee-for-service plan, while still a key part of the Medicaid and Medicare vocabulary, is a rarity in today's managed care world. Under this type of plan, freedom of choice is high for patients and for the medical establishment. Patients with a fee-for-service indemnity or reimbursement plan can choose any physician or facility. Out-of-pocket costs apply until a deductible is satisfied. Each service performed is the unit for payment and treatment decisions are not limited. Efficiency of service providers is not so precious a goal given these contingencies. While fee-for-service remains an option, the need for increased cost control and accountability drove reform that took the shape of managed care.

Managed care organizations vary in cost, efficiency and freedom of choice across an alphabet soup of plan types. To the degree that equitable access to services can be seen as a function of cost for those services, equity also varies across plan types. However, some characteristics are shared among all these plans.

In service of cost-effectiveness, these organizations manage the financing of care delivered to members. For example, 'buying in bulk' achieves lower prices for services from hospitals and practitioners. Efficiency and cost control are enhanced by limiting choice; members are limited to a list of approved physicians, and doctors are restricted to formularies and sanctioned procedures. Another cost-saving measure is the prevalent requirement for referral from a primary physician in order to consult a specialist. This restriction may undermine efficient service delivery, as well as access to services. Choosing a pricier plan can mitigate the restrictions on freedom of choice; however, this poses the broader issues of equity and access.

Of course, the member realizes efficiency benefits in that the plan manages the delivery system: the 'where, what and by whom' of health care. Perhaps the best example of this is the 'one-stop shop' of the HMO.

Health Maintenance Organization (HMO) - staff-model. Everything the member ordinarily needs is efficiently contained in a single location; caregivers and customer service, pharmacy and labs. The HMO premium is paid in advance by the plan member or the member's employer. The size of the premium is independent of the individual plan member's pattern of service utilization. Therefore, the actual cost to the plan for services delivered to members at the high end of the utilization distribution serves to raise the premium for all members.

The premium covers all in-plan services, with the exception of deductibles and co-payments. This is an efficient fiscal arrangement in that it saves administrative costs for the billing process and the member's time in responding to requests for payment. The inclusion of preventive care is a cost-saving strategy, as is the requirement for a referral process.

Requiring referrals may benefit the patient by screening out unnecessary and, thus, inefficient procedures. If misused, however, this requirement becomes a barrier to obtaining necessary care. The potential for misuse is heightened by the practice of casting administrators, rather than caregivers, as architects of the guidelines for appropriate referrals.

Health Maintenance Organization (HMO) - independent practice association (IPA) model. With this type of HMO, the member sacrifices the efficiency of convenience for a greater freedom of choice; the plan sacrifices a modicum of

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control but gains facility-maintenance cost savings. IPAs are comprised of primary care doctors and specialists who see plan members in their own offices. Each doctor may be a participant in several IPAs, thus defraying the added facility-maintenance cost.

Equity can be a greater issue with IPAs than staff-model HMOs; physical/geographic access to care is more variable with the IPA model.

Preferred provider organizations (PPOs) are structured to offer members more freedom of choice in selecting a health care provider than do HMOs. In order to ensure coverage of cost, however, the member is constrained to choose from a defined network of physicians and treatment facilities. Typically, premiums are more costly for this type of plan.

Providers within the network have contractual relationships with the PPO plan, agreeing to treat plan members at a discounted rate. The plan is responsible for recruiting/selecting an equitable mix of providers across locations, as well as for referral coordination and treatment plan review. Providers, who serve 'at the pleasure of the plan,' must operate efficiently or operate at a loss to remain participants in a network.

The final two types of private insurance plans to be discussed are hybrids of those previously described.

Point of service (POS) plans offer greater freedom of choice than other managed care plans, and, therefore, command a higher price. Each point at which a health care service is desired presents an opportunity for the member to choose any service professional at any location to provide that service. Typically, resources characteristic of HMOs, PPOs and traditional fee-for-service plans are available to the POS plan member.

The contingencies that condition this freedom are based on out-of-pocket cost to the member and are part of the agreement for membership in the plan. A different 'level' of cost may be associated with each 'type' of service; e.g., a visit with a physician outside the HMO and PPO entails higher out-of-pocket expense. In many POS plans, choice also is conditioned by the requirement for a primary care physician referral.

Flexibility is high here. A member who prefers the efficient containment of an HMO for a routine physical and lab work may make this choice. The same member, experiencing headaches, may seek service from a clinic specializing in migraines, knowing that a portion of the cost will be absorbed by the plan. However, the cost for this degree of flexibility brings equity into question.

Managed indemnity plans combine the freedom of choice and cost base characteristics of fee-for-service with certain cost-control measures inherent in managed care plans. Members may visit any physician they chose. Typically, members must seek prior approval from the plan administration before certain outpatient procedures and inpatient stays are warranted as covered by the plan. Often, preventive health care is not covered by managed indemnity plans, an arguably inefficient decision.

Freedom of choice is quite pricey with this type of plan. Reimbursement for services is a relatively cumbersome process. The physician or member is required to submit fee-for-service claim forms to the plan. After the member's deductible is satisfied, most plans pay a percentage of what they consider the 'Usual and Customary' charge for covered services. The

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plan generally pays eighty percent of this amount, leaving twenty percent, known as coinsurance, for the member to pay out-of-pocket. If the chosen provider charges more than the Usual and Customary rates, the member is responsible for both the coinsurance and the difference. As with many of the plans discussed, the expense associated with a managed indemnity plan bars many Americans from taking advantage of the benefits offered.

These are the privately-insured health care plans available, in varying degrees, to the American people. Each has strengths and weaknesses, evident in the relative balance of cost, choice, efficiency and equity across plan types.

What publicly-funded options exist and who is eligible?

Medicare is the federally funded health insurance program for Americans age sixty-five and older. Younger citizens with qualifying disabilities also are covered under this program. Medicare falls within the Social Security administration, the federal program charged with providing financial assistance to older Americans, the unemployed and the disabled. The program is funded by taxing employers and employees nationwide.

Sounds like a good and straightforward idea; few would contest that the program has a great to offer and that these benefits are sorely needed.

Medicare is really two health care plans:

Medicare Part A insurance applies to hospital costs. Stays at other 24-facilities, including nursing facilities, psychiatric hospitals and hospice care, also are covered. Part A is free of cost to any Medicare recipient.

Medicare Part B covers many outpatient procedures, doctor visits, lab test, some home health care and in-home use of medical equipment. Medicare-qualified individuals are enrolled automatically in Part B, and the monthly fee is deducted from the person's Social Security payments.

However, a good deal of the medical care one is likely to require is not covered by this program. For example, Medicare does not cover nursing home care or long-term care in the home. Prescription drugs and routine physicals are not covered. Medicare also requires co-payments and deductibles. For seniors and others on a fixed and limited income, these charges add up over time and can serve as a real disincentive to appropriately seeking health care. Choice also is limited by the fact that many doctors do not accept Medicare and, of those that do, some do not accept the Medicare assigned amount as payment in full for all services. This means more out-of-pocket expense for health care services. Fewer doctors opening their doors to Medicare beneficiaries is an access problem, compounded by other barriers, such as the need for transportation and specialized services seniors may require to facilitate health care use.

As a result, seniors able to afford the extra cost (an equity issue) are enrolling in private insurance plans structured to supplement Medicare benefits. Medigap offers one of the most widely available sets of plans for this purpose. Plans A-J, the ten plans available in most states, vary widely in coverage and in cost. Such plans help defray the expense of Medicare co-payments and prescription drugs, for example, but they do not apply to any service that is not covered by Medicare. Given that an acid-test for Medicare coverage is medical necessity, seniors and other Medicare beneficiaries still are in the cold with respect to such services as preventive care and regular check-ups.

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A fairly recent Medicare reform is the introduction of the HMO as a potential care provider. Traditionally, Medicare operates on a fee-for-service basis; patients are billed for each service received. Increasingly, states have begun to offer an HMO alternative to Medicare recipients. This type of public-private partnership for health care service delivery has many proponents and an equal number of critics.

As discussed, HMO services can be more efficient, convenient and comprehensive than a fee-for-service plan. HMOs can compliment Medicare services by offering lower costs, much less paperwork, and a primary care doctor for coordination of care. However, without paying more, the patient is restricted to care providers within the organization. This can be especially troubling for seniors who may bring a long and complex relationship with a particular physician. Also, under HMO guidelines, the patient cannot seek service from a specialist without referral. The HMO model is particularly unsuitable for seniors who spend part of the year is a different location; services simply may be unavailable.

The most terrifying health care issue in the Medicare arena is its potential bankruptcy. According to U.S. Census projections, the Medicare-eligible population will burgeon between the years 2010 and 2030 (when the "baby boom" generation reaches age 65). By 2030, there will be about 71.5 million older persons, more than twice the number in 2000. People age sixty-five and older made up12.4% of the population in 2000; that percentage is expected to increase to 20% by 2030. The number of people eighty-five and older is projected to increase from 4.6 million in 2002 to 9.6 million in 2030. To compound health care equity issues, minority populations are projected to represent 26.4% of the elderly population in 2030, up from 17.2% in 2002 (AoA, 2003).

There are many proposals on the table with the aim of saving the Medicare program. This is one example of a political hot potato that deflects policymakers from the task of solving the overall health care dilemma in America. In President George Bush's proposal to strengthen and modernize Medicare, public-private partnership is at the forefront. He contends that, through private health plans competing for the business of Medicare beneficiaries, better coverage at lower prices can be achieved; also, government gets out of the medical price-setting business. He also foresees government leaving the field of crafting coverage guidelines because competition, again, will yield more flexible and innovative plans.

What about a safety net for Americans who need health care but lack the resources to obtain it?

Medicaid is that safety net for Americans. This is the joint state-federal program for financing health care delivered to people with sufficiently low incomes, or to the chronically ill and disabled. As with Medicare, services traditionally are reimbursed on a fee-for-service basis. Each state commits funding for the program and the Federal government provides a percentage match for these state funds. The rules by which states must run their Medicaid programs are dictated by the Federal government; however, many aspects of the program structure are at the discretion of each state. Therefore, the shape of the program varies from one state to another.

Medicaid is subject to the same problems as Medicare, problems of access, cost, choice, equity and efficiency. Low-income recipients have difficulty locating providers, partly because low-income neighborhoods typically are underserved, but also because many doctors will not accept Medicaid patients. Often, the limited amount Medicaid pays for services is below market rates. Therefore, as previously mentioned, Medicaid recipients are forced to rely on emergency rooms for primary health care services.

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Another similarity to the Medicare program is the move by states to adopt a managed care model for Medicaid recipients. Managed care may correct some of the problems faced by Medicaid beneficiaries. If enrollment is achieved, then locating a provider is unnecessary. Access to preventive care may increase, and the range of coverage may improve.

In the last part of the twentieth century, Medicaid expansions led some to see this as the path to universal coverage; yet it remains a means-tested program, subject to threats of political retrenchment (Grogan & Patashnik, 2003). It should be noted that, without the Medicaid program, the majority of the current 51 million beneficiaries would be without coverage, because, according to the criteria that private insurers currently use to determine whom they will insure, most of these people need not apply (Iglehart, 2003, 2418).

Conclusion

Iglehart (1999) points to the painful conclusion that, for whatever reasons, the United States is alone among industrialized nations in its failure to develop a health care policy that offers basic benefits to all Americans, regardless of their ability to pay. The idea of a single-payer, publicly-funded plan has vocal and prestigious advocates (see Friedman, 2001); equally vocal and powerful advocates speak for the insurance industry and the medical establishment.

The great American nationwide debate regarding how to make health care more widely available to all and still to control cost continues. Questions such as how best how best to measure efficiency in the provision of services, how to structure efficient care, and how efficiency compares with other health care values (e.g., equity and choice), continue as a focus of the debate. The World Health Organization (WHO) defined a fair health care system as one that provides a fair distribution of medical responsiveness across population groups and of financial support, so that everyone is protected equally from the financial risk of illness (Bureau of Labor Education at the University of Maine, 2001). For the United States, the overarching balance of cost, choice, efficiency and equity remains elusive.

References

Administration on Aging (AoA), U.S. Department of Health and Human Services (2003). A Profile of Older Americans: 2003. Washington, D.C...
Bureau of Labor Education at the University of Maine, (2001). The U.S. health care system: Best in the world, or just the most expensive? Issues Brief, Summer, pp. 1-8.
Friedman, M. (2001). How to cure health care. The Public Interest, 142, pp. 3-30.
Grogan, C. & Patashnik, E. (2003). Between welfare medicine and mainstream entitlement: Medicaid at the political crossroads. Journal of Health Politics, Policy & Law, 28(5), pp. 821-858.
Hilsenrath, P., Hill, J., & Levey, S. (2004). Private finance and sustainable growth of national health expenditures. Journal of Health Care Finance, 30(4), pp. 14-20.

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