SEVENTH EDITION

UNDERSTANDING HEALTH POLICY
A CLINICAL APPROACH

THOMAS BODENHEIMER • KEVIN GRUMBACH

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A Clinical Approach

SEVENTH EDITION

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Preface

Understanding Health Policy: A Clinical Approach is a book about health policy as well as individual patients and caregivers and how they interact with each other and with the overall health system. We, the authors, are practicing primary care physicians—one in a public hospital and clinic and the other, for many years, in a private practice. We are also analysts of our nation's health care system. In one sense, these two sides of our lives seem quite separate. When treating a patient's illness, health expenditures as a percentage of gross domestic product or variations in surgical rates between one city and another seem remote if not irrelevant—but they are neither remote nor irrelevant. Health policy affects the patients we see on a daily basis. Managed care referral patterns determine to which specialist we can send a patient; the coverage gaps for outpatient medications in the Medicare benefit package affects how we prescribe medications for our elderly patients; and differences in access to care between families on Medicaid and those with private coverage influences which patients end up seeing one of us in the private sector over the other in a public hospital. In *Understanding Health Policy*, we hope to bridge the gap separating the microworld of individual patient visits and the macrouniverse of health policy.

THE AUDIENCE

The book is primarily written for health science students—medical, nursing, nurse practitioner, physician assistant, pharmacy, social work, public health, and others—who will benefit from understanding the complex environment in which they will work. Physicians feature prominently in the text, but in the actual world of clinical medicine, patients' encounters with other health care givers are an essential part of their health care experience. Physicians would be unable to function without the many other members of the health care team. Patients seldom appreciate the contributions made to their well-being by public health personnel, research scientists, educators, and many other

health-related professionals. We hope that the many nonphysician members of the clinical care, public health, and health science education teams as well as students aspiring to join these teams will find the book useful. Nothing can be accomplished without the combined efforts of everyone working in the health care field.

THE GOAL OF THE BOOK

Understanding Health Policy attempts to explain how the health care system works. We focus on basic principles of health policy in hopes that the reader will come away with a clearer, more systematic way of thinking about health care in the United States, its problems, and the alternatives for managing these problems. Most of the principles also apply to understanding health care systems in other nations.

Given the public's intense concerns about health care in the United States, the book concentrates on the failures of the system. We spend less time on the successful features because they need less attention. Only by recognizing the difficulties of the system can we begin to fix its problems. The goal of this book, then, is to help all of us understand the health care system so that we can better work in the system and change what needs to be changed.

CLINICAL VIGNETTES

In our attempt to unify the overlapping spheres of health policy and health care encounters by individuals, we use clinical vignettes as a central feature of the book. These short descriptions of patients, physicians, and other caregivers interacting with the health care system are based on our own experiences as physicians, the experiences of colleagues, or cases reported in the medical literature or popular press. Most of the people and institutions presented in the vignettes have been given fictitious names to protect privacy. Some names used are emblematic of the occupations, health problems, or attitudes portrayed in the vignettes; most do not have special significance.

OUR OPINIONS

In exploring the many controversial issues of health policy, our own opinions as authors inevitably color and shade the words we use and the conclusions we reach. We present several of our most fundamental values and

perspectives here.

THE RIGHT TO HEALTH CARE

We believe that health care should be a right enjoyed equally by everyone. Certain things in life are considered essential. No one gets excited if someone is turned away from a movie or concert because he or she cannot afford a ticket. But sick people who are turned away from a medical practice can make headlines, and rightly so. A simple statement of the right to health care reads something like this: All people should have equal access to a reasonable level of appropriate health services, regardless of ability to pay.

In 2009, the United States entered into a fierce debate over whether health care should be a right. The debate focused on President Barack Obama's campaign to enact universal health insurance. Following a year of public ferment, Congress passed the Affordable Care Act, which moves in the direction of guaranteeing health care as a right. Yet, at the time of writing this edition of *Understanding Health Policy*, the controversy continues.

THE IMPERATIVE TO CONTAIN COSTS

We believe that limits must be placed on the costs of health care. Cost controls can be imposed in a manner that does relatively little harm to the health of the public. The rapidly rising costs of health care are in part created by scientific advances that spawn new, expensive technologies. Some of these technologies truly improve health, some are of little value or harmful, and others are of benefit to some patients but are inappropriately used for patients whom they do not benefit. Eliminating medical services that produce no benefit is one path to "painless" cost control (see Chapter 8).

Reduction in the rapidly rising cost of administering the health care system is another route to painless cost containment. Administrative excess wastes money that could be spent for useful purposes, either within or outside the health care sector. While large bureaucracies do have the advantage of creating jobs, the nation and the health care system have a great need for more socially rewarding and productive jobs (e.g., home health aides, drug rehabilitation counselors, childcare workers, and many more) that could be financed from funds currently used for needless administrative tasks.

There is a growing consensus that health care cost increases are bad for the economy. Employers complain that the high cost of health insurance for

employees reduces international competitiveness. If government health expenditures continue their rapid rise, other publicly financed programs essential to the nation’s economy (e.g., education and transportation) will be curtailed and the unsustainable government budget deficits will strain the future of the nation’s well-being.

Rising costs are harmful to everyone because they make health services and health insurance unaffordable. Many companies are shifting more health care costs onto their employees. As government health budgets balloon, cutbacks are inevitable, generally hurting the elderly and the poor. Individuals with no health insurance or inadequate coverage have a far harder time paying for care as costs go up. As a general rule, when costs go up, access goes down.

For these reasons, we believe that health care costs should be contained, using strategies that do the least harm to the health of the population.

THE NEED FOR POPULATION-BASED MEDICINE

Most physicians, nurses, and other health professionals are trained to provide clinical care to individuals. Yet clinical care is not the only determinant of health status; standard of living and public health measures have an even greater influence on the health of a population (see Chapter 3). Health care, then, should have another dimension: concern for the population as a whole. Individual physicians may be first-rate in caring for their patients’ heart attacks, but may not worry enough about the prevalence of hypertension, smoking, elevated cholesterol levels, uncontrolled diabetes, and lack of exercise in their city, in their neighborhood, or among the group of patients enrolled in their practices. For years, clinical medicine has divorced itself from the public health community, which does concern itself with the health of the population. We believe that health caregivers should be trained to add a population orientation to their current role of caring for individuals.

ACKNOWLEDGMENTS

We could not have written this book by ourselves. The circumstances encountered by hundreds of our patients and dozens of our colleagues provided the insights we needed to understand and describe the health care system. Any inaccuracies in the book are entirely our responsibility. Our warmest thanks go to our families, who have provided both encouragement

and patience.

Earlier versions of Chapters 2, 4, 5, 8, 9, and 16 were published serially as articles in the *Journal of the American Medical Association* (1994;272:634–639, 1994;272:971–977, 1994;272:1458–1464, 1995;273:160–167, 1995;274:85–90, and 1996;276:1025–1031) and are published here with permission (copyright, 1994, 1995, and 1996, American Medical Association).

CONCLUSION

This is a book about health policy. As such, we will cite technical studies and will make cross-national generalizations. We will take matters of profound personal meaning—sickness, health, caring for individuals in need—and discuss them using the detached language of "inputs and outcomes," "providers and consumers," and "cost-effectiveness analysis." As practicing physicians, however, we are daily reminded of the human realities of health policy. *Understanding Health Policy: A Clinical Approach* is fundamentally about the people we care for: the underinsured janitor with high-deductible insurance enduring the pain of a gallbladder attack because surgery might be unaffordable, or the retired university professor who sustains a stroke and whose life savings are disappearing in nursing home bills uncovered by her Medicare or private insurance plans.

Almost every person, whether a mother on public assistance, a working father, a well-to-do physician, or a millionaire insurance executive, will someday become ill, and all of us will die. Everyone stands to benefit from a system in which health care for all people is accessible, affordable, appropriate in its use of resources, and of high quality.

Thomas Bodenheimer
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San Francisco, California
September 2015

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Introduction: The Paradox of Excess and Deprivation

Louise Brown was an accountant with a 25-year history of diabetes. Her physician taught her to monitor her glucose at home, and her health coach helped her follow a diabetic diet. Her diabetes was brought under good control. Diabetic retinopathy was discovered at yearly eye examinations, and periodic laser treatments of her retina prevented loss of vision. Ms. Brown lived to the age of 88, a success story of the US health care system.

Angela Martini grew up in an inner-city housing project, never had a chance for a good education, became pregnant as a teenager, and has been on public assistance while caring for her four children. Her Medicaid coverage allows her to see her family physician for yearly preventive care visits. A mammogram ordered by her family physician detected a suspicious lesion, which was found to be cancer on biopsy. She was referred to a surgical breast specialist, underwent a mastectomy, was treated with a hormonal medication, and has been healthy for the past 15 years.

For people with private or public insurance who have access to health care services, the melding of high-quality primary and preventive care with appropriate specialty treatment can produce the best medical care in the world. The United States is blessed with thousands of well-trained physicians, nurses, pharmacists, and other health caregivers who compassionately provide up-to-date medical attention to patients who seek

their assistance. This is the face of the health care system in which we can take pride. Success stories, however, are only part of the reality of health care in the United States.

EXCESS AND DEPRIVATION

The health care system in the United States has been called “a paradox of excess and deprivation” (Enthoven & Kronick, 1989). Some persons receive too little care because they are uninsured, inadequately insured, or have Medicaid coverage that many physicians will not accept.

> *James Jackson was unemployed for more than a year but unable to qualify for Medicaid because his state did not expand Medicaid under the 2010 Patient Protection and Affordable Care Act. At age 34, he developed abdominal pain but did not seek care for 10 days because he had no insurance and feared the cost of treatment. He began to vomit, became weak, and was finally taken to an emergency room by his cousin. The physician diagnosed a perforated ulcer with peritonitis and septic shock. The illness had gone on too long; Mr. Jackson died on the operating table. Had he received prompt medical attention, his illness would likely have been cured.*

> *Betty Yee was a 68-year-old woman with angina, high blood pressure, and diabetes. Her total bill for medications, which were only partly covered under her Medicare plan, came to $200 per month. She was unable to afford the medications, her blood pressure went out of control, and she suffered a stroke. Ms. Yee’s final lonely years were spent in a nursing home; she was paralyzed on her right side and unable to speak.*

> *Mary McCarthy became pregnant but could not find an obstetrician who would accept her Medicaid card. After 7 months, she began to experience severe headaches, went to the emergency room, and was found to have hypertension and preeclampsia. She delivered a stillborn baby.*

While some people cannot access the care they need, others receive too much care that is costly and may be harmful.

> *At age 66, Daniel Taylor noticed that he was getting up to urinate twice*

each night. It did not bother him much. His family physician sent him to a urologist, who found that his prostate was enlarged (though with no signs of cancer) and recommended surgery. Mr. Taylor did not want surgery. He had a friend with the same symptoms whose urologist had said that surgery was not needed. Since Mr. Taylor never questioned doctors, he went ahead with the procedure anyway. After the surgery, he became incontinent of urine.

Consuelo Gonzalez had a moderate pain in her back which was relieved by over-the-counter acetaminophen. She went to an orthopedist who ordered an MRI, which showed a small disc protrusion. The doctor recommended surgery, after which Ms. Gonzalez' pain became much worse. She consulted a general internist who told her that the MRI abnormality was not serious, that the surgery had been unnecessary, and that physical therapy might help. After a year of physical therapy, the pain subsided back to its original level.

Too Little Care

In February 2015, a year after the Patient Protection and Affordable Care Act was fully implemented, 26 million people in the United States remained without health insurance, down from 41 million in 2013 (Carman et al., 2015). In addition, many people with health insurance have inadequate coverage. In December 2014, 46% of Americans surveyed reported having trouble affording health care (Rosenthal, 2015).

Too Much Care

According to health services expert Robert Brook:

… almost every study that has seriously looked for overuse has discovered it, and virtually every time at least double-digit overuse has been found. If one could extrapolate from the available literature, then perhaps one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications could be done without. (Brook, 1989)

A 2003 study found that elderly patients in some areas of the country receive 60% more services—hospital days, specialty consultations, and medical procedures—than similar patients in other areas; the patients

receiving fewer services had the same mortality rates, quality of care, access to care, and patient satisfaction as those receiving more services (Fisher et al., 2003a and 2003b). In 2012, waste in health care was estimated at between $558 and $910 billion per year—from 21% to 34% of total health care expenditures (Berwick & Hackbarth, 2012).

THE PUBLIC'S VIEW OF THE HEALTH CARE SYSTEM

Health care in the United States encompasses a wide spectrum, ranging from the highest-quality, most compassionate treatment of those with complex illnesses, to the turning away of the very ill because of lack of ability to pay; from well-designed protocols for prevention of illness to inappropriate high-risk surgical procedures performed on uninformed patients. While the past decades have been witness to major upheavals in health care, one fundamental truth remains: the United States has the least universal, most costly health care system in the industrialized world (Commonwealth Fund, 2015).

Many people view the high costs of care and the lack of universal access as indicators of serious failings in the health care system. In 2009, only 25% of people in the United States believed that the system was working well, well below the percentage in 14 other developed nations (Commonwealth Fund, 2015).

UNDERSTANDING THE CRISIS

In order to correct the weaknesses of the health care system while maintaining its strengths, it is necessary to understand how the system works. How is health care financed? What are the causes and consequences of incomplete access to care? How are physicians paid, and what is the effect of their mode of reimbursement on health care costs? How are health care services organized and quality of care enhanced? Is sufficient attention paid to the prevention of illness, and what are different strategies for preventing illness?

How can the problems of health care be solved? Did the Patient Protection and Affordable Care Act enacted in 2010 provide the answer? Can costs be controlled in a manner that does not reduce access? Can access be expanded in a manner that does not increase costs? How have other nations done it—or attempted to do it? How might the health care system in the United States

change in the future?

REFERENCES

Berwick DM, Hackbarth AD. Eliminating waste in US health care. *JAMA*. 2012;307:1513–1516.

Brook RH. Practice guidelines and practicing medicine. *JAMA*. 1989;262:3027–3030.

Carman KG et al. Trends in health insurance enrollment, 2013-15. *Health Aff (Millwood)*. 2015;34:1044–1048.

Commonwealth Fund. 2014 International Profiles of Health Care Systems. January 2015.

Enthoven A, Kronick R. A consumer-choice health plan for the 1990s. *N Engl J Med*. 1989;320:29–37.

Fisher ES et al. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Ann Intern Med*. 2003a;138: 273–287.

Fisher ES et al. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. *Ann Intern Med*. 2003b;138:288–298.

Rosenthal E. Insured but not covered. *New York Times*. February 7, 2015.

2

Paying for Health Care

Health care is not free. Someone must pay. But how? Does each person pay when receiving care? Do people contribute regular amounts in advance so that their care will be paid for when they need it? When a person contributes in advance, might the contribution be used for care given to someone else? If so, who should pay how much?

Health care financing in the United States evolved to its current state through a series of social interventions. Each intervention solved a problem but in turn created its own problems requiring further intervention. This chapter will discuss the historical process of the evolution of health care financing. The enactment in 2010 of the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act, ACA, or "Obamacare," created major changes in the financing of health care in the United States.

MODES OF PAYING FOR HEALTH CARE

The four basic modes of paying for health care are out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing (Table 2–1). These four modes can be viewed both as a historical progression and as a categorization of current health care financing.

Table 2–1. Health care financing in 2013[a]

Type of Payment	Percentage of National Health Expenditures, 2013
Out-of-pocket payment	12%
Individual private insurance	3%
Employment-based private insurance	30%[b]
Government financing	47%
Other	8%
Total	100%
Principal Source of Coverage	**Percentage of Population, 2013**
Uninsured	13%
Individual private insurance	7%
Employment-based private insurance	47%
Government financing	33%
Total	100%

These figures precede implementation of most of the Affordable Care Act.

Source: Data extracted from Hartman M et al. National health spending in 2013: growth slows, remains in step with the overall economy. *Health Aff* 2015;34:150–160; US Census Bureau: Health Insurance Coverage in the United States, 2013. September, 2014.

[a]Because private insurance tends to cover healthier people, the percentage of expenditures is far less than the percentage of population covered. Public expenditures are far higher per population because the elderly and disabled are concentrated in the public Medicare and Medicaid programs.

[b]This includes private insurance obtained by federal, state, and local employees which is in part purchased by tax funds.

Out-of-Pocket Payments

Fred Farmer broke his leg in 1913. His son ran 4 miles to get the doctor, who came to the farm to splint the leg. Fred gave the doctor a couple of chickens to pay for the visit. His great-grandson, Ted, who is uninsured, broke his leg in 2013. He was driven to the emergency room, where the physician ordered an x-ray and called in an orthopedist who placed a cast on the leg. The cost was $2,800.

One hundred years ago, people like Fred Farmer paid physicians and other health care practitioners in cash or through barter. In the first half of the twentieth century, out-of-pocket cash payment was the most common method of payment. This is the simplest mode of financing—direct purchase by the consumer of goods and services (Fig. 2–1).

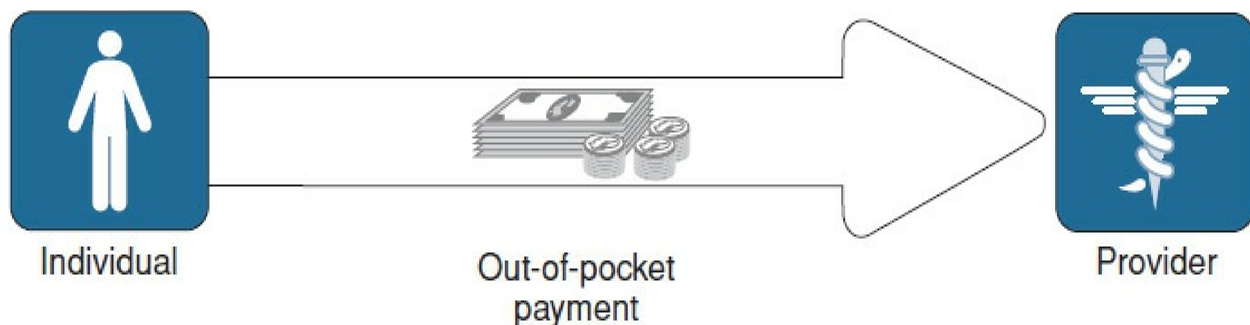


Figure 2–1. Out-of-pocket payment is made directly from patient to provider.

People in the United States purchase most consumer items and services, from gourmet restaurant dinners to haircuts, through direct out-of-pocket payments. This is not the case with health care (Arrow, 1963; Evans, 1984), and one may ask why health care is not considered a typical consumer item.

Need Versus Luxury

Whereas a gourmet dinner is a luxury, health care is regarded as a basic human need by most people.

For 2 weeks, Marina Perez has had vaginal bleeding and has felt dizzy. She has no insurance and is terrified that medical care might eat up her $500 in savings. She scrapes together $100 to see her doctor, who finds

that her blood pressure falls to 90/50 mm Hg upon standing and that her hematocrit is 26%. The doctor calls Marina's sister Juanita to drive her to the hospital. Marina gets into the car and tells Juanita to take her home.

If health care is a basic human right, then people who are unable to afford health care must have a payment mechanism available that is not reliant on out-of-pocket payments.

Unpredictability of Need and Cost

Whereas the purchase of a gourmet meal is a matter of choice and the price is shown to the buyer, the need for and cost of health care services are unpredictable. Most people do not know if or when they may become severely ill or injured or what the cost of care will be.

Jake has a headache and visits the doctor, but he does not know whether the headache will cost $100 for a physician visit plus the price of a bottle of ibuprofen, $1,200 for an MRI, or $200,000 for surgery and irradiation for brain cancer.

The unpredictability of many health care needs makes it difficult to plan for these expenses. The medical costs associated with serious illness or injury usually exceed a middle-class family's savings.

Patients Need to Rely on Physician Recommendations

Unlike the purchaser of a gourmet meal, a person in need of health care may have little knowledge of what he or she is buying at the time when care is needed.

Jenny develops acute abdominal pain and goes to the hospital to purchase a remedy for her pain. The physician tells her that she has acute cholecystitis or a perforated ulcer and recommends hospitalization, an abdominal CT scan, and upper endoscopic studies. Will Jenny, lying on a gurney in the emergency room and clutching her abdomen with one hand, use her other hand to leaf through a textbook of internal medicine to determine whether she really needs these services, and should she have brought along a copy of Consumer Reports to learn where to purchase them at the cheapest price?

Health care is the foremost example of asymmetry of information between providers and consumers (Evans, 1984). A patient with abdominal pain is in a poor position to question a physician who is ordering laboratory tests, x-rays, or surgery. When health care is elective, patients can weigh the pros and cons of different treatment options, but even so, recommendations may be filtered through the biases of the physician providing the information. Compared with the voluntary demand for gourmet meals, the demand for health services is partially involuntary and is often physician rather than consumer-driven.

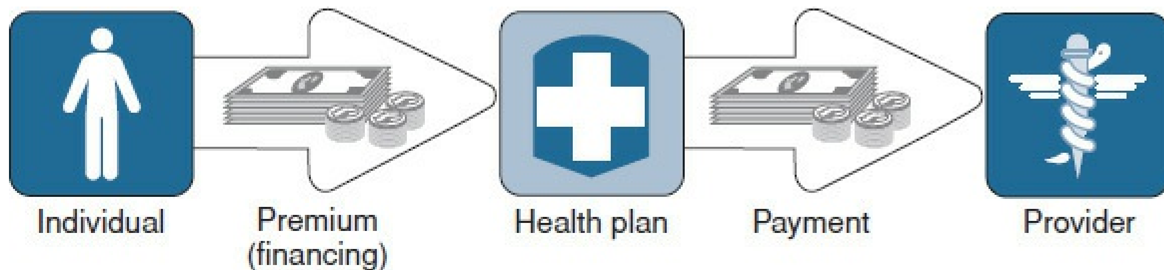
For these reasons among others, out-of-pocket payments are flawed as a dominant method of paying for health care services. Because the direct purchase of health services became increasingly difficult for consumers and was not meeting the needs of hospitals and physicians to be reliably paid, health insurance came into being.

Individual Private Insurance

In 2012, Bud Carpenter was self-employed. To pay the $500 monthly premium for his individual health insurance policy, he had to work extra jobs on weekends, and the $5,000 deductible meant he would still have to pay quite a bit of his family's medical costs out of pocket. Mr. Carpenter preferred to pay these costs rather than take the risk of spending the money saved for his children's college education on a major illness. When he became ill with leukemia and the hospital bill reached $80,000, Mr. Carpenter appreciated the value of health insurance. Nonetheless he had to feel disgruntled when he read a newspaper story listing his insurance company among those that paid out on average less than 60 cents for health services for every dollar collected in premiums.

With private health insurance, a third party, the insurer is added to the patient and the health care provider, who are the two basic parties of the health care transaction. While the out-of-pocket mode of payment is limited to a single financial transaction, private insurance requires two transactions—a premium payment from the individual to an insurance plan (also called a health plan), and a payment from the insurance plan to the provider (Fig. 2–2). In nineteenth-century Europe, voluntary benefit funds were set up by guilds, industries, and mutual societies. In return for paying a monthly sum, people received assistance in case of illness. This early form of private health

insurance was slow to develop in the United States. In the early twentieth century, European immigrants set up some small benevolent societies in US cities to provide sickness benefits for their members. During the same period, two commercial insurance companies, Metropolitan Life and Prudential, collected 10 to 25 cents per week from workers for life insurance policies that also paid for funerals and the expenses of a final illness. The policies were paid for by individuals on a weekly basis, so large numbers of insurance agents had to visit their clients to collect the premiums as soon after payday as possible. Because of the huge administrative costs, individual health insurance never became a dominant method of paying for health care (Starr, 1982). In 2013, prior to the implementation of the individual insurance mandate of the ACA, individual policies provided health insurance for 7% of the US population (Table 2–1).



▲ **Figure 2–2.** Individual private insurance. A third party, the insurance plan (health plan), is added, dividing payment into a financing component and a payment component. The ACA added an individual coverage mandate for those not otherwise insured and federal subsidy to help individuals pay the insurance premium.

In 2014, Bud Carpenter signed up for individual insurance for his family of 4 through Covered California, the state exchange set up under the ACA. Because his family income was 200% of the federal poverty level, he received a subsidy of $1,373 per month, meaning that his premium would be $252 per month (down from his previous monthly premium of $500) for a silver plan with Kaiser Permanente. His deductible was $2,000 (down from $5,000). Insurance companies were no longer allowed to deny coverage for his pre-existing leukemia.

The ACA has many provisions, described in detail in the Kaiser Family Foundation (2013a) Summary of the Affordable Care Act and discussed more in Chapter 15. One of the main provisions is a requirement (called the “individual mandate”) that most US citizens and legal residents who do not have governmental or private health insurance purchase a private health

insurance policy through a federal or state health insurance exchange, with federal subsidies for individual and families with incomes between 100% and 400% of the federal poverty level ($24,250 to $97,000 for a family of four). Details of the individual mandate are provided in Table 2–2.

Table 2–2. Summary of the Individual Mandate Provisions of the Affordable Care Act (ACA), 2015

U.S. citizens and legal residents are required to have health coverage with exemptions available for such issues as financial hardship. Those who choose to go without coverage pay a tax penalty of $325 or 2% of taxable income in 2015, which gradually increases over the years. People with employer-based and governmental health insurance are not required to purchase the insurance required under the individual mandate.

Tax credits to help pay health insurance premiums increase in size as family incomes rise from 100% to 400% of the Federal Poverty Level. In addition subsidies reduce the amount of out-of-pocket costs individuals and families must pay; the amount of the subsidy varies by income.

Under the individual mandate, health insurance is purchased though insurance marketplaces called health insurance exchanges. Seventeen states have elected to set up their own exchanges; the remainder of states are covered by the federal exchange, Healthcare.gov.

Insurance companies marketing their plans through the exchanges offer four benefit categories:

- Bronze plans represent minimum coverage, with the insurer paying for 60% of a person’s health care costs, with high out-of-pocket costs but low premiums
- Silver plans cover 70% of health care costs, with fewer out-of-pocket costs and higher premiums
- Gold plans cover 80% of costs, with low out-of-pocket costs and high premiums
- Platinum plans cover 90% of costs, with very low out-of-pocket costs and very high premiums

Most people who have obtained insurance through the exchanges have picked Bronze or Silver plans, and 87% have received a subsidy. A

family of four with income at 150% of the federal poverty level receives an average subsidy of $11,000. At 300% of the federal poverty level the subsidy is about $6,000.

Source: Kaiser Family Foundation. Summary of the Affordable Care Act. 2013. http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act. Accessed March 12, 2015.

Employment-Based Private Insurance

Betty Lerner and her schoolteacher colleagues each paid $6 per year to Prepaid Hospital in 1929. Ms. Lerner suffered a heart attack and was hospitalized at no cost. The following year Prepaid Hospital built a new wing and raised the teachers' prepayment to $12.

Rose Riveter retired in 1961. Her health insurance premium for hospital and physician care, formerly paid by her employer, had been $25 per month. When she called the insurance company to obtain individual coverage, she was told that premiums at age 65 cost $70 per month. She could not afford the insurance and wondered what would happen if she became ill.

The development of private health insurance in the United States was impelled by the increasing effectiveness and rising costs of hospital care. Hospitals became places not only in which to die, but also in which to get well. However, many patients were unable to pay for hospital care, and this meant that hospitals were unable to attract "customers."

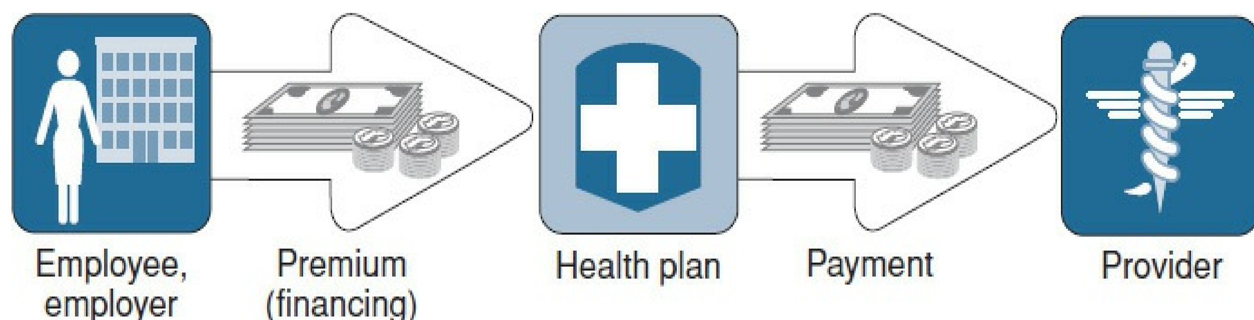
In 1929, Baylor University Hospital agreed to provide up to 21 days of hospital care to 1,500 Dallas schoolteachers such as Betty Lerner if they paid the hospital $6 per person per year. As the Great Depression deepened and private hospital occupancy in 1931 fell to 62%, similar hospital-centered private insurance plans spread. These plans (anticipating health maintenance organizations [HMOs]) restricted care to a particular hospital. The American Hospital Association built on this prepayment movement and established statewide Blue Cross hospital insurance plans allowing free choice of hospital. By 1940, 39 Blue Cross plans controlled by the private hospital industry had enrolled over 6 million people. The Great Depression reduced the amount patients could pay physicians out of pocket, and in 1939, the California Medical Association set up the first Blue Shield plan to cover physician services. These plans, controlled by state medical societies,

followed Blue Cross in spreading across the nation (Starr, 1982; Fein, 1986).

In contrast to the consumer-driven development of health insurance in European nations, coverage in the United States was initiated by health care providers seeking a steady source of income. Hospital and physician control over the "Blues," a major sector of the health insurance industry, guaranteed that payment would be generous and that cost control would remain on the back burner (Law, 1974; Starr, 1982).

The rapid growth of employment-based private insurance was spurred by an accident of history. During World War II, wage and price controls prevented companies from granting wage increases, but allowed the growth of fringe benefits. With a labor shortage, companies competing for workers began to offer health insurance to employees such as Rose Riveter as a fringe benefit. After the war, unions picked up on this trend and negotiated for health benefits. The results were dramatic: Enrollment in group hospital insurance plans grew from 12 million in 1940 to 142 million in 1988.

With employment-based health insurance, employers usually pay much of the premium that purchases health insurance for their employees (Fig. 2–3). However, this flow of money is not as simple as it looks. The federal government views employer premium payments as a tax-deductible business expense. The government does not treat the health insurance fringe benefit as taxable income to the employee, even though the payment of premiums could be interpreted as a form of employee income. Because each premium dollar of employer-sponsored health insurance results in a reduction in taxes collected, the government is in essence subsidizing employer-sponsored health insurance. This subsidy is enormous, estimated at $250 billion per year (Ray et al., 2014).



▲ **Figure 2–3.** Employment-based private insurance. In addition to the direct employer subsidy, indirect government subsidies occur through the tax-free status of employer contributions for health insurance benefits.

The ACA made a change in employer-based health insurance, requiring employers with 50 or more full-time employees to offer coverage or pay a fee to the government; the fee is meant to discourage employers from dropping employee health insurance, which they might be tempted to do since their employees could buy individual insurance through the health insurance exchanges (Kaiser Family Foundation, 2013b).

The growth of employment-based health insurance attracted commercial insurance companies to the health care field to compete with the Blues for customers. The commercial insurers changed the entire dynamic of health insurance. The new dynamic was called **experience rating.** (The following discussion of experience rating can be applied to individual as well as employment-based private insurance.)

> *Healthy Insurance Company insures three groups of people—a young healthy group of bank managers, an older healthy group of truck drivers, and an older group of coal miners with a high rate of chronic illness. Under experience rating, Healthy sets its premiums according to the experience of each group in using health services. Because the bank managers rarely use health care, each pays a premium of $300 per month. Because the truck drivers are older, their risk of illness is higher, and their premium is $500 per month. The miners, who have high rates of black lung disease, are charged a premium of $700 per month. The average premium income to Healthy is $500 per member per month.*

> *Blue Cross insures the same three groups and needs the same $500 per member per month to cover health care plus administrative costs for these groups. Blue Cross sets its premiums by the principle of community rating. For a given health insurance policy, all subscribers in a community pay the same premium. The bank managers, truck drivers, and mine workers all pay $500 per month.*

Health insurance provides a mechanism to distribute health care more in accordance with human need rather than exclusively on the basis of ability to pay. To achieve this goal, funds are redistributed from the healthy to the sick, a subsidy that helps pay the costs of those unable to purchase services on their own.

Community rating achieves this redistribution in two ways:

1. Within each group (bank managers, truck drivers, and mine workers), people who become ill receive benefits in excess of the premiums they pay, while people who remain healthy pay premiums while receiving few or no health benefits.
2. Among the three groups, the bank managers, who use less health care than their premiums are worth, help pay for the miners, who use more health care than their premiums could buy.

Experience rating is less redistributive than community rating. Within each group, those who become ill are subsidized by those who remain well, but among the different groups, healthier groups (bank managers) do not subsidize high-risk groups (mine workers). Thus the principle of health insurance, which is to distribute health care more in accordance with human need rather than exclusively on the ability to pay, is weakened by experience rating (Light, 1992).

In the early years, Blue Cross plans set insurance premiums by the principle of community rating, whereas commercial insurers used experience rating as a “weapon” to compete with the Blues (Fein, 1986). Commercial insurers such as Healthy Insurance Company could offer cheaper premiums to low-risk groups such as bank managers, who would naturally choose a Healthy commercial plan at $300 over a Blue Cross plan at $500. Experience rating helped commercial insurers overtake the Blues in the private health insurance market. While in 1945 commercial insurers had only 10 million enrollees, compared with 19 million for the Blues, by 1955 the score was commercials 54 million and the Blues 51 million.

Many commercial insurers would not market policies to such high-risk groups as mine workers, leaving Blue Cross with high-risk patients who were paying relatively low premiums. To survive the competition from the commercial insurers, Blue Cross had no choice but to seek younger, healthier groups by abandoning community rating and reducing the premiums for those groups. In this way, many Blue Cross and Blue Shield plans switched to experience rating. Without community rating, older and sicker groups became less and less able to afford health insurance.

From the perspective of the elderly and those with chronic illness, experience rating is discriminatory. Healthy persons, however, might have another viewpoint and might ask why they should voluntarily transfer their wealth to sicker people through the insurance subsidy. The answer lies in the

unpredictability of health care needs. When purchasing health insurance, an individual does not know if he or she will suddenly change from a state of good health to one of illness. Thus, *within a group*, people are willing to risk paying for health insurance, even though they may not use it. *Among different groups*, however, healthy people have no economic incentive to voluntarily pay for community rating and subsidize another group of sicker people. This is why community rating cannot survive in a market-driven competitive private insurance system (Aaron, 1991).

In a major reform contained within the ACA, insurers are severely limited in using experience rating to set premiums; they can only vary premiums based on family size, geographic location, age, and smoking status. The ACA also limits how much premiums can differ between older and younger individuals (Kaiser Family Foundation, 2013b).

The most positive aspect of health insurance—that it assists people with serious illness to pay for their care—has also become one of its main drawbacks—the difficulty in controlling costs in an insurance environment. With direct purchase, the “invisible hand” of each individual’s ability to pay holds down the price and quantity of health care. However, if a patient is well insured and the cost of care causes no immediate fiscal pain, the patient will use more services than someone who must pay for care out of pocket. In addition, particularly before the advent of fee schedules, health care providers could increase fees more easily if a third party was available to foot the bill.

Thus health insurance was originally an attempt by society to solve the problem of unaffordable health care under an out-of-pocket payment system, but its very capacity to make health care more affordable created a new problem. If people no longer had to pay out of their own pockets for health care, they would use more health care; and if health care providers could charge insurers rather than patients, they could more easily raise prices, especially during the era when the major insurers (the Blues) were controlled by hospitals and physicians. The solution of insurance fueled the problem of rising costs. As private insurance became largely experience rated and employment based, persons who had low incomes, who were chronically ill, or who were elderly found it increasingly difficult to afford private insurance.

Government Financing

In 1984 at age 74 Rose Riveter developed colon cancer. She was now