

Chapter 3

Paying for Health Care

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OBJECTIVES

After studying this chapter, the student should be able to

1. Explain the role of health insurance in the healthcare system.
2. Describe the historical evolution of health insurance in the United States.
3. Identify different kinds of government and non-government health insurance.
4. Explain the difference in eligibility and coverage between Medicare and Medicaid programs.

INTRODUCTION

Medical professionals, not insurance company bureaucrats, should be making health care decisions.

US Senator Barbara Boxer, California

Senator Boxer and others are committed to making quality health care more accessible and affordable for Americans. Presidential candidates have health care availability at the forefront of every campaign. The United States has some of the finest health care in the world, yet not all citizens can afford the high cost of healing. The best way to provide health care to all is an ongoing debate in political arenas and living rooms across the nation. As you read about the significant training, education, and advances in treatment and diagnostic technology in the professional chapters of this text, you may begin to understand why health care is the 1.7 trillion dollar business it is. As an example, Blue Cross/Blue Shield estimates a couple

having their first baby in a hospital is facing a medical bill ranging from \$6,800–\$9,800 for prenatal care and the delivery at a hospital (BCBS, 2006). That estimate is for a normal, healthy, vaginal birth without complications. A cesarean birth with the surgery, anesthesiology, and extended hospital stay can easily cost double that. Considering that many pregnancies in this country are unintended, it may be safe to assume that often couples do not have the funds to pay for this in their pockets. Could you save that much money in nine months?

Your Money for Your Life

Because of advances in medicine and medical technology, medical treatment is more expensive. People in developed countries are living longer, thus the population of those countries is aging. A larger group of senior citizens requires more medical care than a young healthier population. Some other factors that cause an increase in health insurance prices are health related: insufficient exercise; unhealthy food choices; a shortage of doctors in impoverished or rural areas; excessive use of alcohol or street drugs, smoking, and obesity among some parts of the population; and the modern sedentary lifestyle of the middle classes.

Fortunately, many individuals have some type of health insurance to cover the cost of receiving health care. According to the United States Census Bureau figures, roughly 85% of Americans have health insurance. Approximately 60% obtain health insurance through their place of employment or as individuals, and various government agencies provide health insurance to 25% of Americans. Unfortunately, many individuals do not have a means to help pay for expensive medical treatments. If you recall from Chapter 2, the Census Bureau reported that 45 million Americans lacked health insurance in 2003, an increase of 1.4 million from 2002 (DeNavas-Walt et al., 2005). The high cost of health care ultimately reaches into all of our pockets. For example, manufacturers may charge more for their products to recover the expense of providing insurance to their employees. Federal government and state taxes pay for services like Medicare and Medicaid and health insurance for children. Both the federal government and states support mental health programs, health departments, community hospitals, and other healthcare programs. All feel the social costs of limited access to health care. To improve the quality and quantity of life and reduce disparities between populations, goals of Healthy People 2010 is expensive business.

Health Insurance

Illness or non-work-related injury can be financially devastating, especially when considering the rising cost of health care over the past 20 years. Health insurance can help protect against large out-of-pocket healthcare expenses that can accumulate during an acute or chronic illness. Health insurance is a prepayment plan providing services or medical care needed in times of illness or disability. Health insurance includes voluntary plans, either commercial or nonprofit, or compulsory national insurance plans, usually connected with a Social Security program. Understanding the options, benefits, and limitations of health insurance is important for both personal and professional reasons. Eventually, students will graduate and join the work force, or at least that is what their parents hope! Employees often have to select health insurance from their employer's options. Many students in the health professions will rely on health insurance to pay their salaries in their future careers. A basic understanding will benefit both perspectives, as it is wise to be informed consumers when health is the product.

As with other forms of insurance, for your car and your home, health insurance helps relieve the burden of unexpected events: a little money is put away regularly in case expensive medical care is needed later. Every year, the cost of health care increases dramatically. Simple same-day surgeries, required tests, and emergency attention can add up to thousands of dollars or more. Having health insurance provides many benefits. Individuals are less likely to avoid seeking care because it costs too much. This may improve health, extend life expectancy, and add to quality of life. A health insurance policy is a contract between an insurer and an individual or group, in which the insurer agrees to provide specified health insurance at an agreed-upon price (the premium). Depending on the type of policy, the premium may be payable either in a lump sum or in installments. Health insurance usually provides either direct payment or reimbursement for expenses associated with illnesses and injuries.

Health insurance is one of the most controversial forms of insurance because of the perceived conflict between the need for the insurance company to remain solvent versus the need of its customers to remain healthy, which many view as a basic human right. Critics of private health insurance claim that this conflict of interest is why state and federal regulation of health insurance companies is necessary. Some say that this conflict exists in a liberal healthcare system because of the unpredictability of how patients respond to medical treatment. Proponents of regulation argue that too many health insurance companies put their desire for profits above the welfare of the consumer or patient.

Why Do You Need Health Insurance?

Let's face it—health insurance is a necessity in today's world. Even if you are healthy today and have never had any major problems in the past, you simply cannot predict the future. The costs of medical care and treatment have soared to new heights in recent years. There are enormous medical costs for individuals with a major injury or suddenly stricken with a life-threatening illness. In addition to medical emergencies, routine conditions requiring visits to a physician happen all the time. This is especially true for children. Ear infections, rashes, and high fevers are commonplace with infants and children; numerous trips to the doctor can be expensive without health insurance. Uninsured people live with such risk every day of their lives. Health insurance protects against that risk.

Historical Perspective on Health Insurance in the United States

While perpetually a topic of heated conversation in the political arena, paying for health care is not a new issue. In the past, health insurance in the United States took the form of voluntary programs. Such programs date from about 1850, when cooperative mutual benefit and fraternal beneficiary associations provided health insurance. Commercial companies introduced limited coverage, and subsequently established many plans offered by industries and labor unions.

Advocacy of government health insurance in the United States began in the early 1900s. Theodore Roosevelt made national health insurance one of the major planks of the Progressive Party during the 1912 presidential campaign, and in 1915 a model bill for health insurance was presented, but defeated, in numerous state legislatures. After 1920, opposition to government-sponsored plans led by the American Medical Association (AMA), was said to be motivated by the fear that government participation in medical care might lead to socialized medicine, a government-regulated system for providing health care for all by means of subsidies derived from taxation. Even today, the AMA opposes socialized medicine because these programs seek to impose predetermined clinical practice guidelines on patients without consideration of the best interests of those patients based on the advice of their physicians (*Columbia Encyclopedia*, 2006).

Over the years in the United States, societies of practicing physicians set up many health insurance plans, but the largest enrollment has been in Blue Cross

and Blue Shield plans. These were set up as community-sponsored, nonprofit service plans based on contracts with hospitals and with subscribers or health-care consumers. Most general voluntary plans accept subscribers, in groups or as individuals. These plans extend coverage to dependents and exclude accidents and diseases covered by workers' compensation laws. Although valuable in cushioning the financial distress caused by illness or injury, voluntary health insurance not only limits benefits in order to avoid prohibitive premium rates but also excludes many people, particularly the poor, who cannot afford it, and senior citizens, for whom the cost is often prohibitive. By the mid-1990s, many of the Blue Cross companies, which had been suffering financially, were reorganizing, and by 2002 more than 20% of Blue Cross members were covered by plans that had converted to for-profit status (*Columbia Encyclopedia*, 2006).

During the middle of the 20th century, it became apparent that legislation was necessary to provide medical care for the elderly. In 1965, during President Lyndon B. Johnson's administration, federal legislation in the form of Medicare for the aged and Medicaid for the indigent was enacted. Since 1966, both public and private health insurance has played a key role in financing healthcare costs in the United States (*Columbia Encyclopedia*, 2006).

Government programs and insurance now cover the bulk of all medical bills. While the number of people covered by some form of health insurance increased over the past decades, those individuals have seen significant cost increases. As premiums increased, many businesses increased the amount of money employees contribute toward their health insurance. This situation has led to continuing political pressure for restructuring of the national healthcare insurance system.

Congress debated many bills for a national health insurance plan in the 1960s and 1970s, and in 1973 it passed the Health Maintenance Organization (HMO) Act, which provided grants to employers who set up HMOs. Unlike insurers, HMOs provide care directly to patients; hence, they are viewed as low-cost alternatives to hospitals and private doctors (*Columbia Encyclopedia*, 2006).

Managed care is a concept in US health care that rose to dominance during the presidency of Ronald Reagan as a means to control Medicare payouts. Managed care is based on an effort to control escalating healthcare costs by the health insurance industry, which supposedly defines a reasonable maximum fee which healthcare providers may charge for any given service. Providers are ostensibly bound to accept these maximum fees if they wish to be listed in directories of specific insurance companies, which are provided to their policy holders as referral directories of "approved" physicians.

The rise of managed care was credited by the health insurance industry for the lessened rate of medical inflation seen in much of the 1990s in the United States; in some years of that decade the rate of increase in the price of medical goods and services was little more than the overall rate of general inflation.

However, this effect now seems to largely have ended, and US medical inflation is once again two or three times the rate of overall inflation, as it was during much of the 1980s (*Columbia Encyclopedia*, 2006).

In 1993, President Clinton, elected on a promise of healthcare reform, proposed a national health insurance program that ultimately would have provided coverage for most citizens. Opposition by insurance, medical, small business, and other groups killed it. In 1999, Clinton and Congress battled over developing a “patient’s bill of rights,” to protect people from denial of service and other HMO limitations. Many individual states have developed their own health insurance alternatives by

- Using managed healthcare systems that monitor the type of services offered and have set fees for each service.
- Expanding Medicaid to help serve formerly ineligible patients.
- Establishing statewide or small-business health insurance alliances that pool people into a large group that has more buying power.

While we cannot ignore the millions that have no health insurance, it is helpful to understand the wide variety of programs available to the individuals who do have coverage. According to the National Center for Health Statistics of the CDC, there are private plans, government plans, state-specific plans, and even insurance plans offered by the Indian Health Service. Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company. These may be offered by an employer or a union. Employment-based health insurance is coverage offered through one’s own employment or a relative’s. Direct-purchase health insurance is coverage through a plan purchased by an individual from a private company (NCHS, 2006). The different types of coverage will be discussed in detail later in this chapter.

Government health insurance includes plans funded at the federal, state, or local level. The major categories of government health insurance are Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), military health care, state plans, and the Indian Health Service. Medicare is the federal program that helps pay healthcare costs for people 65 and older and certain people under 65 with long-term disabilities. Medicaid is a program administered at the state level that provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. The State Children’s Health Insurance Program is a program administered at the state level, providing health care to low-income children whose parents do not qualify for Medicaid. SCHIP may be known by different names in different states.

Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian

Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).

Some states have their own health insurance programs for low-income uninsured individuals. These health plans, known by different names in different states, vary in coverage and eligibility. Indian Health Service (IHS) is a healthcare program through which the Department of Health and Human Services provides medical assistance to eligible Native Americans at IHS facilities. In addition, the IHS helps pay the cost of selected healthcare services provided at non-IHS facilities (NCHS, 2006).

What Kinds of Non-government Health Insurance are There?

According to the Insurance Information Institute, there are essentially two kinds of health insurance: Fee-for-Service and Managed Care. Although these plans differ, they both cover an array of medical, surgical, and hospital expenses. Most plans cover prescription drugs and some also offer dental coverage (III, 2006b). A brief description of each type follows.

- **Fee-for-Service**

These plans generally assume that the medical professional is paid a fee for each service provided to the patient. Patients are seen by a doctor of their choice and the insurance claim is filed by either the medical provider or the patient.

- **Managed Care**

More than half of all Americans have some kind of managed-care plan for their health insurance. Various plans work differently and can include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans. These plans provide comprehensive health services to their members and offer financial incentives to patients who use the providers in the plan.

Traditional Fee-for-Service Insurance (Indemnity Policies)

Most indemnity policies allow individuals to choose any doctor and hospital that they wish when seeking healthcare services. Indemnity in this case means protection, as by insurance, from liabilities or penalties incurred by

one's actions. The hallmark of traditional fee-for-service insurance is choice—the choice of what provider to visit when seeking covered medical services with few if any geographic limitations. When purchasing an indemnity policy there is often a deductible, the amount required to pay before policy benefits are provided. There may be options regarding the amount of the deductible. If individual healthcare charges are covered, or eligible for payment under the policy, any applicable deductible will apply. Once the deductible has been paid, the remaining charges are reimbursed to the individual at a specified percentage according to the policy contract. A *co-payment* is the difference between eligible charges and the percentage paid, and is normally the participant's responsibility. The policy or an employee benefit booklet (if the indemnity policy is group coverage) will spell out the terms and conditions of what is covered and what is not covered (III, 2006b).

Health Maintenance Organizations

A health maintenance organization (HMO) is a type of managed healthcare system. HMOs and preferred provider organizations (PPOs) share the goal of reducing healthcare costs by focusing on preventative care and implementing utilization management controls. Unlike many traditional insurers, HMOs do not merely provide financing for medical care. The HMO actually delivers the treatment as well. Doctors, hospitals, and insurers all participate in the business arrangement known as an HMO. In practice, an HMO is an insurance plan under which an insurance company controls all aspects of the health care of the insured. In the design of the plan, each member is assigned a “gatekeeper,” a primary care physician (PCP), who is responsible for the overall care of members assigned to him/her. Specialty services require a specific referral from the PCP to the specialist. Non-emergency hospital admissions also require specific pre-authorization by the PCP. Typically, services are not covered if performed by a provider who is not an employee of, or specifically approved by, the HMO, unless it is an emergency situation as defined by the HMO. Instead of deductibles, most HMOs have nominal co-payments. In return for this fee, most HMOs provide a wide variety of medical services, from office visits to hospitalization and surgery. With a few exceptions, HMO members must receive their medical treatment from physicians and facilities within the HMO network. The size of this network varies depending on the individual HMO.

The focus of many HMOs is on wellness and preventative care. By reducing out-of-pocket costs and paperwork, HMOs encourage members to seek

medical treatment early, before health problems become severe. In addition, many HMOs offer health education classes and discounted health club memberships. Unlike most health insurance plans, HMOs generally do not place a limit on your lifetime benefits. The HMO will continue to cover your treatment as long as you are a member (III, 2006b).

Preferred Provider Organizations

Like an HMO, a preferred provider organization (PPO) is a managed healthcare system. However, there are several important differences between HMOs and PPOs. A PPO is actually a group of doctors and/or hospitals that provides medical service only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees, or members of the sponsor(s) at discounted rates and may set up utilization-control programs to help reduce the cost of medical care. In return, the sponsor(s) attempts to increase patient volume by creating an incentive for employees or policyholders to use the physicians and facilities within the PPO network.

Rather than prepaying for medical care, PPO members pay for services as rendered. The PPO sponsor (employer or insurance company) generally reimburses the member for the cost of the treatment, less any co-payment percentage. In some cases, the physician may submit the bill directly to the insurance company for payment. The insurer then pays the covered amount directly to the healthcare provider, and the member pays his or her co-payment amount. The healthcare providers and the PPO sponsor negotiate the price for each type of service in advance. PPO members are not required to seek care from PPO physicians. However, there is generally strong financial incentive to do so. Reimbursement for PPO physicians is often greater than for non-network physicians. For example, members may receive 90% reimbursement for care obtained from network physicians but only 60% for treatment provided by non-network physicians.

Healthcare costs paid out of your own pocket (for example, deductibles and co-payments) are limited with most PPOs. Typically, out-of-pocket costs for network care are limited to \$1,200 for individuals and \$2,100 for families. Out-of-pocket costs for non-network treatment are typically capped at \$2,000 for individuals and \$3,500 for families (III, 2006).

Point of Service Plans

A Point of Service (POS) plan is a type of managed healthcare system that combines characteristics of the HMO and the PPO. Like an HMO, members pay no deductible and usually only a minimal co-payment when they use a healthcare provider within the PPO network. Members also must choose a primary care physician who is responsible for all referrals within the POS network. If they choose to go outside the network for health care, POS coverage functions more like a PPO. Members will likely be subject to a deductible (around \$300 for an individual or \$600 for a family), and the co-payment required will be a substantial percentage of the physician's charges (usually 30–40%).

POS coverage allows you to maximize your freedom of choice. As with a PPO, you can mix the types of care you receive. For example, your child could continue to see his pediatrician who is not in the network, while you receive the rest of your health care from network providers. This freedom of choice encourages members to use network providers but does not require it, as with HMO coverage. As with HMO coverage, members pay only a nominal amount for network care. Usually, their co-payment is around \$10 per treatment or office visit. Unlike HMO coverage, however, they always retain the right to seek care outside the network at a lower level of coverage. When choosing to use network providers, there is generally no deductible, as long as members stay within the POS network of physicians. If members choose to go outside the POS network for treatment, they are free to see any doctor or specialist they choose without first consulting a primary care physician (PCP). Of course, they will pay substantially more out-of-pocket charges for non-network care. Healthcare costs paid out of the member's own pocket (that is, deductibles and co-payments) are typically limited. The average yearly limit for individuals is around \$2,400. For families, the average yearly limit is approximately \$4,000. In a catastrophic illness, these limits help reduce the financial burden to the members.

As in a PPO, there is generally strong financial incentive to use POS network physicians. For example, the co-payment may be only \$10 for care obtained from network physicians, but members could be responsible for up to 40% of the cost of treatment provided by non-network doctors. In most cases, individuals must reach a specified deductible before coverage begins on out-of-network care. On average, individual deductibles are around \$300 per year, and the average annual family deductible is about \$600. This deductible amount is *in addition* to the higher co-payment for out-of-network care. As in an HMO, members must choose a primary care physician (PCP) who provides general medical care and must be consulted before seeking

care from another doctor or specialist within the network. This screening process helps to reduce costs both for the POS and for POS members, but it can also lead to complications if a PCP does not provide the referral needed (III, 2006).

Other Types of Health-Related Insurance

Vision care insurance is insurance that provides coverage for services relating to the care and treatment of the eyes. It typically covers services delivered by an optometrist or ophthalmologist. Some vision plans may provide more extensive coverage (such as certain eye surgeries), while others may limit coverage to “reasonable and customary” charges incurred during routine eye exams. Reasonable and customary charges generally don’t include the cost of glasses and contact lenses. With some employer-sponsored vision plans, coverage may be even more narrowly limited to the medical treatment of certain eye conditions. This is rare, however.

Dental insurance may provide direct payment to the dentist for the dental care and treatment you receive. Or you may be required to cover the applicable charges out-of-pocket at the time of service, and then file a claim for reimbursement. It depends on the specific plan. Dental insurance has become more common in recent years. Of the roughly 55% of Americans who have dental insurance, most receive their coverage through their employer. Employer-sponsored dental insurance may take the form of a health insurance plan that includes dental coverage, a separate dental plan, or a benefit choice within a cafeteria plan (III, 2006b).

Picking a Non-government Health Plan: Considerations

With so many health insurance options, how do you choose? There are some important differences between indemnity plans, HMOs, PPOs, and POS plans worthy of understanding. As a future (or current) consumer, you should make every effort to understand your own health insurance policy, and become familiar with common health insurance provisions, including limitations, exclusions, and riders. It is important to know what your policy covers, and what you will have to pay in out-of-pocket expenses. When comparing health insurance policies, you should strive to balance coverage against cost. While price is an important consideration, other factors also

may influence your decision when the time comes to choose a health insurance plan.

A good health insurance policy contains several types of coverage. Basic insurance includes hospital, surgical, and physicians' expense coverage. In addition, major medical coverage is necessary in case of a catastrophic accident or illness. These may be purchased separately, but you will generally get more complete coverage if they are combined in a single policy. Your policy should discuss the cost of each type of coverage and describe exactly what each pays for. A health insurance policy also contains important information regarding out-of-pocket costs, namely deductibles and co-payments. The family coverage provisions will be important as well, if a spouse or dependents are covered by the policy. Information about out-of-pocket maximums and benefit ceilings should also be included.

The Insurance Information Institute suggests employees ask the following questions when deciding on health insurance options. It is crucial to understand health insurance choices and pick the insurance that is best for you and your family (III, 2006a).

How affordable is the cost of care?

- What is the monthly premium I will have to pay?
- Should I try to insure most of my medical expenses or just the large ones?
- What deductibles will I have to pay out-of-pocket before insurance starts to reimburse me?
- After I've met my deductible, what percentage of my medical expenses are reimbursed?
- How much less am I reimbursed if I use doctors outside the insurance company's network?

Does the insurance plan cover the services I am likely to use?

- Are the doctors, hospitals, laboratories, and other medical providers that I use in the insurance company's network?
- If I want to use a doctor outside the network, will the plan permit it?
- How easily can I change primary care physicians if I want to?
- Do I need to get permission before I see a medical specialist?
- What are the procedures for getting care and being reimbursed in an emergency situation, both at home and out of town?
- If I have a preexisting medical condition, will the plan cover it?
- If I have a chronic condition such as asthma, cancer, AIDS, or alcoholism, how will the plan treat it?

- Are the prescription medicines that I use covered by the plan?
- Does the plan reimburse alternative medical therapies such as acupuncture or chiropractic treatment?
- Does the plan cover the costs of delivering a baby?

What is the quality of the insurance plan I'm looking at?

- How have independent government and non-government organizations rated the plan? For example, the National Committee for Quality Assurance (NCQA) (<http://www.ncqa.org>) issues a Consumer Assessment of Health Plans (CAHPS) report for every medical plan and facility.
- What kind of accreditation has the plan received from groups such as NCQA or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (<http://www.jcaho.org>)?
- How many patient complaints were filed against the plan last year and how many were upheld by state regulatory agencies like the state insurance commission or the state medical licensing board?
- How many members drop out of the plan each year? State insurance departments keep track of “dis-enrollment rates.”
- Do the doctors, pharmacies, and other services in the plans offer convenient times and locations?
- Does the plan pay for preventive health care such as diet and exercise advice, immunizations, and health screenings?
- What do my friends and colleagues say about their experiences with the plan?
- What does my doctor say about his or her experience with the plan?

If you do not have health insurance right now, you should seriously consider purchasing it as soon as possible. No one can predict the future—you do not know when you might suffer an accident or become seriously ill. Health insurance can help to protect you against financial ruin.

Government-Sponsored Health Insurance Programs

Some people would like to see some form of national health insurance to pay for medical care for everyone. Others would keep the system as it currently exists. Congress, the President, state legislatures, doctors, insurance companies, and private citizens are talking about rising health costs and proposing ways to deal with this issue. Government-sponsored programs such as Medicare and Medicaid do not provide care directly, but rather

contract with healthcare professionals, hospitals, and HMOs to deliver services to their beneficiaries.

On July 30, 1965, President Lyndon Johnson signed legislation that created the Medicaid program. Medicaid has grown from its origins as a health coverage program for welfare recipients into a public health insurance program for the nation's low-income population as well as the predominant long-term care program for the elderly and individuals with disabilities. The combined federal, state, and local governments' role in financing healthcare services has evolved from a relatively minor one, to one of major importance for the healthcare services provided to millions of people in the United States. However, like many "40-somethings," a mid-life crisis is in the making for Medicaid. Will its programs be able to support the health care needs of the surge of citizens over 65?

Overview of Medicaid

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. It was created as a joint federal-state program to provide medical assistance to aged, disabled, or blind individuals (or to needy, dependent children) who could not otherwise afford the necessary medical care. Medicaid is the largest source of funding for medical and health-related services for some of America's poorest people (DeParle, 2000).

Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

Medicaid pays for a number of medical costs, including hospital bills, physician services, home health care, and long-term nursing home care. States may elect to provide other services for which federal matching funds are available.

Some of the most frequently covered optional services are clinic services, medical transportation, services for the mentally retarded in intermediate care facilities, prescribed drugs, optometrist services and eyeglasses, occupational therapy, prosthetic devices, and speech therapy.

Who Is Eligible for Medicaid?

Medicaid does not provide medical assistance for *all* poor persons. Under the broadest provisions of the federal statute, Medicaid does not provide health-care services even for very poor persons unless they are in a “categorically needy” eligibility group. Low income is only one test for Medicaid eligibility; individuals’ resources also are tested against threshold levels determined by each state within federal guidelines.

The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes—for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) The poverty guidelines issued by the Department of Health and Human Services (DHHS) are the other version of the federal poverty measure. The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for federal programs such as Medicaid. The poverty guidelines are sometimes loosely referred to as the “federal poverty level” (FPL).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional “state-only” programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds do not support state-only programs. The following enumerates the mandatory Medicaid “categorically needy” eligibility groups for which federal matching funds are provided (CMS, 2005):

- Most individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996.
- Children under age 6 whose family income is at or below 133% of the federal poverty level (FPL).

- Pregnant women whose family income is below 133% of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).
- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries.

States also have the option of providing Medicaid coverage for other “categorically related” groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

The Balanced Budget Act (BBA) of 1997 amended federal Medicaid law in the areas of eligibility, benefits, premiums and cost sharing, provider reimbursement and participation, managed care, and federal financial assistance. In addition to making Medicaid changes, the BBA also created the State

Table 3.1 2006 HHS Poverty Guidelines

<i>Persons in Family or Household</i>	<i>48 Contiguous States and D.C.</i>	<i>Alaska</i>	<i>Hawaii</i>
1	\$ 9,800	\$12,250	\$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

Source: Federal Register, 2006.

Children's Health Insurance Program (SCHIP), or Title XXI of the Social Security Act. SCHIP allows states to expand their Medicaid programs to cover additional uninsured children, or to create non-Medicaid insurance programs to accomplish the same goal (CMS, 2005).

Welfare reform also repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides states with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other requirements as well—in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law (CMS, 2005).

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations (CMS, 2005). These services generally include the following:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings

- Early and periodic screening and diagnostic and treatment (EPSDT) services for children under age 21

States may also receive federal matching funds to provide certain optional services. Following are the most common of the 34 currently approved optional Medicaid services:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Rehabilitation and physical therapy services
- Home and community-based care to certain persons with chronic impairments

The BBA included a state option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well.

Amount and Duration of Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the US Department of Health and Human Services. The CMS administers the Medicare program and works in partnership with the states to administer Medicaid and State Children's Health Insurance Programs. Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition (CMS, 2005).

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) medically necessary healthcare services that are identified under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for eligible children, and that are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan; and (2) states may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, states may not provide room and board for the beneficiaries). With certain exceptions, a state's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely (CMS, 2005).

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay healthcare providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries, for certain services.

Medicaid, initially formulated as a medical care extension of federally funded programs, provided cash income assistance for the poor with an emphasis on dependent children and their mothers, the disabled, and the elderly. Legislative changes over the years resulted in incremental expansion of Medicaid focusing on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2001, for example, indicate that Medicaid payments for services for 23.3 million children, who constitute 50% of all Medicaid beneficiaries, average about \$1,305 per child (a relatively small average expenditure per person). Similarly, for 11.6 million adults, who comprise 25% of beneficiaries, payments average about \$1,725 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.4 million aged, constituting 9% of all Medicaid beneficiaries, average about \$10,965 per person; for 7.7 million disabled, who comprise 16% of beneficiaries, payments average about \$10,455 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2001 payments to healthcare vendors for 47.0 million Medicaid beneficiaries average \$3,965 per person (CMS, 2005).

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41% of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2001 show that Medicaid payments for nursing facility services totaled \$37.2 billion for more than 1.7 million beneficiaries of these services—an average expenditure of \$21,890 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$3.5 billion for more than 1.0 million beneficiaries—an average expenditure of \$3,475 per home healthcare beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase (CMS, 2005).

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid managed care programs to develop innovative healthcare delivery or reimbursement systems. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14% of enrollees in 1993 to 59% in 2003 (CMS, 2005).

More than 46.0 million persons received healthcare services through the Medicaid program in 2001. In 2003, total outlays for the Medicaid program (federal and state) were \$278.3 billion, including direct payment to providers

of \$197.3 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$52.1 billion, payments to disproportionate share hospitals of \$12.9 billion, and administrative costs of \$16.0 billion. Outlays under the SCHIP program in 2003 were \$6.1 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach \$445 billion and \$7.5 billion, respectively, by 2009 (CMS, 2005).

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries. Starting January 2006, the new Medicare prescription drug benefit provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid also receive the low-income subsidy for both the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid will no longer provide drug benefits for Medicare beneficiaries.

Medicare

Medicare is a federal program that provides health insurance to retired individuals, regardless of their medical condition. Most people become eligible for Medicare upon reaching age 65 and becoming eligible for Social Security retirement benefits. In addition, individuals may be eligible if they are disabled or have end-stage renal disease. Any individual who is receiving Social Security benefits is automatically enrolled in Medicare at age 65 when he or she becomes eligible. However, those who delay retirement until after age 65 must remember to enroll in Medicare at age 65 anyway, because enrollment won't be automatic. Medicare coverage consists of two parts—Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). A third part, Medicare Part C (Medicare+Choice), is a program that allows you to choose from several types of healthcare plans. Everyone with Medicare, regardless of income, health status, or prescription drug usage, will have access to prescription drug coverage as of January 1, 2006 under Medicare Part D. Medicare Part D prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies in your area. Medicare prescription drug coverage provides protection for people who have very high drug costs (CMS, 2005). Each category of Medicare coverage is described in the following sections.

- **Medicare Part A (hospital insurance):** Generally known as hospital insurance, Part A covers services associated with inpatient hospital care (that is, the costs associated with an overnight stay in a hospital, skilled

nursing facility, or psychiatric hospital, such as charges for the hospital room, meals, and nursing services). Part A also covers hospice care and home health care.

- **Medicare Part B (medical insurance):** Generally known as medical insurance, Part B covers other medical care. Physician care—whether it was received while you were an inpatient at a hospital, at a doctor’s office, or as an outpatient at a hospital or other healthcare facility—is covered under Part B. Also covered are laboratory tests, physical therapy or rehabilitation services, and ambulance service.
- **Medicare Part C (Medicare+Choice):** The 1997 Balanced Budget Act expanded the kinds of private healthcare plans that may offer Medicare benefits to include managed care plans, medical savings accounts, and private fee-for-service plans. The new Medicare Part C programs are in addition to the fee-for-service options available under Medicare Parts A and B.
- **Medicare Part D prescription drug coverage:** This insurance covers both brand-name and generic prescription drugs at participating pharmacies in your area. Medicare prescription drug coverage provides protection for people who have very high drug costs. Everyone with Medicare is eligible for this coverage, regardless of income and resources, health status, or current prescription expenses.

Who Administers the Medicare Program?

The Centers for Medicare and Medicaid Services (CMMS), a division of the US Department of Health and Human Services, has overall responsibility for administering the Medicare program. Although the Social Security Administration processes Medicare applications and claims, the CMMS sets standards and policies. However, beneficiaries deal mostly with the private insurance companies that actually handle the claims on the local level for individuals receiving Medicare coverage. Insurance companies handling Medicare Part A claims are called Medicare intermediaries, and insurance companies handling Part B claims are called Medicare carriers. Managed care plans handle Part C claims. Although the same private insurance company may handle both Part A and Part B claims, Part A and Part B are very different regarding administration (for example, different deductibles and co-payment requirements). There is virtually no overlap; it is as if participants have two separate health insurance policies.

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eli-

gible for full Medicaid coverage, the Medicare healthcare coverage is supplemented by services that are available under their state's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Medicaid and Long-Term Nursing Home Care

Over 60% of all nursing home residents receive Medicaid benefits that help pay for their care. An aging population and the increased cost of long-term care have made Medicaid planning an important topic. In years past, attorneys and financial planners devised strategies for the middle class and people of means to qualify for Medicaid by transferring funds to family members and by establishing trusts. Consequently, Congress tightened the Medicaid rules regarding the transfer of assets. The Omnibus Reconciliation Act of 1993 makes qualifying for Medicaid more difficult for those people who transfer their assets away without receiving fair value in return. If individuals transfer assets away for less than fair consideration within 36 months of their application for Medicaid, the law creates a waiting period before they can collect Medicaid benefits. Transfers into certain trusts within 60 months of a Medicaid application also will also cause a period of ineligibility.

Health Insurance Covering our Smallest Citizens: State Children's Health Insurance

Although Medicaid has made great strides in enrolling low-income children, significant numbers of children remain uninsured. From 1988 to 1998, the proportion of children insured through Medicaid increased from 15.6% to 19.8%. At the same time, however, the percentage of children without health insurance increased from 13.1% to 15.4%. The increase in uninsured children is mostly the result of fewer children being covered by employer-sponsored health insurance. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a program initiated by the Balanced Budget Act. In addition to allowing states to craft or expand an existing state insurance program, SCHIP provides more federal funds for

states to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. As part of the Balanced Budget Act of 1997, SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. SCHIP is the single largest expansion of health insurance coverage for children since the initiation of Medicaid in the mid-1960s (CMS, 2005).

SCHIP is designed to provide coverage to “targeted low-income children.” A “targeted low-income child” is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income 50% higher than the state’s Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families and not just children. As of September 30, 1999, each of the states and territories had an approved SCHIP plan in place. SCHIP offers states three options when designing a program. The state can either

- use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program;
- design a separate children’s health insurance program entirely separate from Medicaid; or,
- combine both the Medicaid and separate program options.

Children’s health insurance programs are not welfare programs. Everyone has a stake in making sure America’s children are healthy. These programs support working families and low-income families alike in providing health insurance to their children. *Insure Kids Now!* is a national campaign to link the nation’s 10 million uninsured children—from birth to age 18—to free and low-cost health insurance. Many families simply do not know their children are eligible. The states have different eligibility rules, but in most states, uninsured children 18 years old and younger whose families earn up to \$34,100 a year (for a family of four) are eligible (CMS, 2005).

Nationalized Health Care

Many countries have made the societal choice to avoid this important conflict by nationalizing the health industry so that doctors, nurses, and other medical workers become state employees, all funded by taxes; or setting up a

national health insurance plan that all citizens pay into with tax or quasi-tax payments and which pays private doctors for health care. These national healthcare systems also have their problems. Some of these countries have citizen groups which protest bureaucracy and cost-cutting measures that unduly delay medical treatment. Similar issues exist with private health management insurances (HMO) in countries with privately funded medicine.

Future Challenges

With the advent of DNA testing, previously unknown risk factors involving genetic makeup will become known and this is expected to lead to greater pressure on the private health insurance industry as they try to limit their exposure to high-risk individuals. As larger groups of these individuals are identified and charged higher premiums (if they can get coverage at all) the pressure on privacy laws to limit the flow of personal medical data will only increase. HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Centers for Medicare & Medicaid Services (CMS) are responsible for implementing various unrelated provisions of HIPAA, therefore HIPAA may mean different things to different people. This legislation is important to healthcare providers as well as a protection of the healthcare consumer. Chapter 4 addresses HIPAA and the implications for healthcare professionals.

SUMMARY

In April 2006, the state of Massachusetts became the first to propose universal health care for all its citizens, requiring all state residents to have health insurance through an individual mandate on the purchase of health insurance, with government subsidies to ensure affordability. This innovative bipartisan bill is an attempt to cover 95% of the state's uninsured population within 3 years (Kaiser, 2006). Those with access to health insurance are often asked to pay increasing premiums and co-payments for their health coverage.

Employers, in efforts to curb costs of providing insurance to their workers, raise deductibles to reduce their premium rates. Quality health care is expensive! The economic impact of the current epidemic of obesity alone, and the subsequent health problems related to obesity and lack of physical activity in this country, will be staggering. To achieve Healthy People 2010 objectives of improving the quality and quantity of life and reduce disparities within populations, access to health care is critical. Someone has to pay for that care. As a nation, we will likely see many innovative proposals to expand coverage to keep more individuals healthy.

ADDITIONAL RESOURCES

Consumer information on the various health insurance plans that exist today is available from the following leading insurance trade associations. They are:

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite 500
Washington, DC 20004
<http://www.ahip.org>

Insurance Information Institute
110 William Street
New York, NY 10038
212-346-5500
<http://www.iii.org/>

Life and Health Foundation for Education

2175 K Street, NW—Suite 250
Washington, DC 20037
<http://www.life-line.org>

Medicare and Medicaid and SCHIP

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
1-800-MEDICARE
<http://www.cms.hhs.gov/>

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