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Cost Efficiency of Managed Care

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Cost Efficiency of Managed Care

Tammie M. Scott-Thorpe

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Masters of Science on Corporate Communications

1996

ABSTRACT

This paper studies the role of health maintenance organizations in the health care market. Managed Care represents the growing wave of health care in the future by eliminating unnecessary and costly procedures. Vanishing are the repetitive tests that once victimized the consumer. By regulating fixed costs, the industry is forcing a change in testing and research.

Since Managed Care regulates costs, they appear particularly prominent in the elderly population. Financial efficiency helps provide the proper organized system of long term care brought by the aged. Also, complex paper work and bills should be eliminated or at least decreased to a great extent, and comprehensive coverage added to the growing population of aged or retired persons.

The cost effectiveness of Managed Care has helped to bear arms in the fight against rising health care costs. Discounted contractual rates attained by virtue of agreements with providers is one step taken in this direction. By assessing fixed figures for specialized services, providers are left with little alternative but to reduce costs to avert large write-offs. Many sources such as economic, political and social sources encourage the growth of prepayment in order to contain costs.

Consumers can benefit by referral to providers that specialize in the care they are seeking. In addition, the consumers financial liability is reduced by having to pay percentages of discounted rates, or in some cases have care provided for them at no cost.

Thus, prepayment plans which are initiated by some Managed Care plans can be cost efficient for the entire community. Not only do consumers benefit but doctors and hospitals also prosper. Doctors are granted fixed rates and attract additional patients by merely being a certain company's approved provider. In the authors view, if the medical staff of a hospital works with a managed care plan on the same "team," a hospital would probably keep beds filled and remain competitive with other hospitals in the market. Ultimately, it is very important that HMOs and hospitals work together to ensure a smooth working network. Sacrifices are made but overall benefits may be realized by all participating parties.

Cost Efficiency of Managed Care

Tammie M. Scott-Thorpe

A Culminating Project Presented to the Faculty of
the Graduate School of Lindenwood College in Partial
Fulfillment of the Requirements for the Degree of
Master of Science

1996

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DEDICATION

This paper is dedicated to two very important people in my life. First, to Geri Miller, who has been supportive and encouraging especially when it came to returning to school; then most of all to my father, Michael Scott Sr.. He has been supportive and encouraging my entire life and I thank God for having a father like him. Thanks to both and I love you dearly.

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CHAPTER I

Integrated Health Care System

In communities across the nation, healthcare providers are coming together to form delivery systems that propose to eliminate duplication of services and improve the continuum of care for patients, from the doctors office to the hospital and back into the patient's home. This trend is causing a major restructuring of the hospital industry.

Hospitals and healthcare providers are identifying with trends in today's environment to create new alliances and mergers with the goal of developing seamless delivery systems called Integrated Healthcare Networks. This approach is more common in an environment with increasing numbers of managed care organizations such as HMOs, PPOs or state managed Medicaid and Medicare programs as they begin to penetrate a market. In addition, environmental forces, the restructuring of the provider network, philosophical and functional changes of the major payers, and managed competition are also influencing the development of new health care networks.

One of the most significant changes in the healthcare industry is the rapid growth of "Integrated Healthcare Systems." Integrated

healthcare systems are defined as "networks of organizations that provide or arrange to provide a coordinated continuum of healthcare services to a defined population and are willing to be held fiscally and clinically accountable for the healthcare status of the population served." ("The Perloff Report" 43-47) These networks link the physician, specialist, hospitals, and ancillary providers into an "at risk" delivery system. Under this structure, each component becomes a cost center to the network rather than the profit center they had once been. These networks are designed to make healthcare more efficient, better manage care costs, make organizations more price competitive, and maintain their viability. ("The Perloff Report" 43-47)

Several indicators have been prevalent during the past 20 years that suggested a move toward integrated regional health as the model of the future. The Perloff Report was presented in 1970 which identified the community based health care organization as the hub of the health care system. This community based health-care organization was to be regional in scope, serve as a geographically defined population and was an attempt to ensure that access to healthcare was attainable by all. This report indicated that it was the responsibility of this organization to provide comprehensive continuity of care and recognize the need to control the utilization of facilities and services. In addition, they needed

to provide appropriate and economic use of health care resources without duplicating facilities or services. This model served to become the model for the vertical integrated health care system.("Vantage Point: Integrated healthcare systems are the path to the future" 10)

Managed Care

The United States' share in the cost of health care has grown significantly in the last 40 years. The Health Care Financing Administration (HCFA) projected that according to present trends, health care spending would reach 15 percent of the GNP by the year 2000. These expenditures have added to deficits in the public sector, threatened the viability and solvency of some companies and created heavy burdens for many people. At the same time, approximately 35 million individuals do not have health insurance or any other coverage, and millions more have inadequate coverage. Because historically the fee-for-service payment of health providers has provided an open-ended source of finance and consumer are largely unconcerned and unaware of the costs of the services they receive, HCFA has proposed a strategy of managed care. (Inglehart 327-742)

Managed Care is defined as "a collection of interdependent systems that integrate the financing and delivery of health care services by incorporating the following elements:

- specific standards and guidelines for selecting providers
- arrangements with selected providers to furnish health care services to members

- formal programs for ongoing quality assurance and utilization review
- financial incentives for members to use plan providers and plan procedures." (Inglehart, 327-742)

From the broader perspective, managed care is any plan or mechanism that attempts to impact the price health care, the site where services is provided, and /or the utilization of services. Traditionally, health care has been provided by independent doctors, hospitals and other health care providers. Managed care provides a delivery system that contractually links doctors, hospitals, and insurance plans. The traditional form of reimbursement has been straight "fee-for -service". Generally speaking, this was the most attractive method of reimbursement to providers since it allowed them to bill for services rendered and receive payment with minimal accountability to the payor. Organizations began to take steps to move from being a "payer" of health care services, that is, covering bills as they were submitted, to being a prudent purchaser. Private purchasers were frustrated that costs continued to escalate despite the adoption of some managed care measures. In addition, the administrative complications of dealing with multiple plans and vendors had been considerable. The job of the human resources department had been complicated by the plethora of

health benefit options available, not to mention burgeoning choices in related fringe benefits areas such as child care, elder care and pensions. Private payers have viewed the need to shift from the tradition fee-for-service to managed care. (Inglehart 327-742)

The same environmental forces driving health care costs were also driving the need for managed care. These include:

- The aging of the population and the associated severity of their illnesses
- High-priced technology
- Excess capacity of hospitals and other providers
- Inefficient management of health care resources
- Care that is medically unnecessary and inappropriate or service that are ineffective
- Focus on acute care rather than on preventive medicine
- Inflation, both general and health care related
- Malpractice insurance rates a "defensive" medical practices
- Inflated demand caused by patient insensitivity to price (Inglehart 327-742)

While these factors seem overwhelming, the market momentum towards managed care is being driven more than anything else by payer demand

for slowing down the growth rate of members' medical expenses. (Inglehart 327-742)

The recent submission of health care legislation by President Clinton has reinforced that concern for both the public and privately financed payers to solidify their purchasing power. Reform measures in the legislation would force health care organizations to assume both fiscal and health status risk for their defined population. Reimbursement structures will change. "Fee-for service" and prospective pay systems are being phased out (except for Medicare) in favor of fixed price orientation for all health care product lines such as primary care services, long-term care, outpatient and rehabilitation services. Legislation also includes provisions to provide clinical outcomes designed to measure disease trends and the effect of various treatment patterns. In other words, clinical outcome research would provide a means for payers to assess if the services they purchase actually improve the health status and are delivered in cost-beneficial manner. (Inglehart 327-742)

Public and Private payers expect reform legislation to promote cooperation among the various health care entities - the physicians, hospital, ancillary providers, and community health organizations by aligning economic incentive and prohibiting duplication of services.

Reform measures would force consolidation of institutions and services by encouraging the development of health care systems, increasing local competition and decreasing the rate of operational and capital spending. (Schneider, 10-13) Implementation of proposed legislation had the potential to achieve economies of sale and improved access to health services. Regardless of whether this legislation passes, reforms based on the general principles for health reform and the effect of environmental influences have already begun to change the health care industry. Americans private and public payers are convinced that managed care plans will reduce costs compared with the current cost trends of traditional fee-for-service medicine. They are accelerating their efforts to promote plans that integrate the delivery and financing of care in place of constraints on encounters between the patient and the provider.

Types of Managed Care Organization

The features of managed care organizations are:

- contracts with selected physicians and hospitals which provide comprehensive services to enrolled members for predetermined monthly premium.
- utilization and quality control that health care providers must accept
- financial incentives for patients to use the providers associated with the plan
- the assumption of financial risk through captivation rates to participating providers
- the philosophical acceptance of health care providers to balance the patient's need against the need to control cost. (Ingelhart 342-742)

There are a number of managed care models. The most noticeable of the models that provide managed care are called either Health Maintenance Organizations (HMOs) of various types or Preferred Provider Organizations (PPOs).

HMOs are the best known and the earliest form of managed care. They are organized health care systems designed to provide a wide range of comprehensive health care services for a specific patient population at a predetermined fee per enrollee. In effect, they are responsible for the financing and the delivery of comprehensive health care services. Five commonly recognized models of HMOs are group, staff, network, IPA, direct contracts and networks. The major difference among these models pertains to the relationship between the HMO and its participating physicians. (Inglehart 342-750)

In group-model and staff-model HMOs, care is provided almost entirely by multi-specialty groups of salaried physicians who practice in common facilities provided by the owners of the HMO.

- **STAFF MODEL:** Staff model HMO employs physicians directly.

These physicians provide services at or through facilities owned by the HMO. Staff models offer physicians a ready-made practice, with relatively fixed hours and a salary plus bonus based on the H M O s performance or profitability. (Schneider 10-13)

- **GROUP MODEL:** In this arrangement, the HMO contracts with a multi-specialty group practice. The contracted group receives either a capitated payment or a percentage if the HMO's premium is exchanged for providing primary and specialty care services to persons enrolled in the HMO. (Schneider 10-13)

- **INDIVIDUAL PRACTICE ASSOCIATION:** The IPA model is the most prevalent of the models. In Individual Practice Association (IPA) type HMOs, physicians practice in their own office and devote only a portion of their practice to servicing the IPA's subscriber. In these instances where the IPA is an independent, organized entity the HMO either pays the IPA a capitation or percentage of premium amount in consideration for the IPA arranging and providing services to the HMO members. (Schneider 10-13)

- **IPA/DIRECT CONTRACTING:** Physician participation is achieved through a contract directly between the physician and the HMO. Generally speaking, physicians are free to contract with more than one HMO and are compensated on a capitation basis or on a fee-for-service basis. (Schneider 10-13)

- **NETWORK MODEL:** A network model plan is a combination of individual practice associations medical groups, staff employed physicians under contract with the HMO. It is essentially a hybrid variation of one or more of the above models. (Schneider 10-13)

Group and staff models are largely responsible for management of care within a fixed budget and have generally been more successful at controlling cost that the IPA. The IPA's are generally managed by insurance companies and focus on cost over quality and are reimbursed based on fee-for-service. (Relman 133-135)

Another model of managed care is the Preferred Provider Organization (PPO). A PPO is a group of health care providers both professional and institutional which contracts with employers, insurance carriers or third party administrators to provide medical services to enrollees subject to certain utilization and cost containment procedures. A number of hybrid PPO organizations exist:

- Physician-Hospital Affiliations designed to vertically integrate provider services.
- Hospital Affiliations where two or more hospitals develop an alliance to offer a broader spectrum of services within a geographic area.

- Physician Network Affiliations designed to negotiate directly with hospitals, payers and employers.
- Hospital - Commercial Payor Affiliations established by a commercial insurance company and hospital groups designed to share risk and to market vertically integrated services to employers. (Relman 133-135)

PPOs are growing in number and are a good cost-saving compromise for those resistant to the constraints that come with joining an HMO. Similar to HMOs, PPO organizations are reimbursed at discounted rates, however, unlike HMOs which restrict the patient's choice, PPOs retain the concept of freedom of choice.

Issues and Limitations

In viewing managed care and managed care organizations, there are five key principles that apply:

1. Reduce consumer administrative requirements
2. Reduce utilization, especially in inpatient service
3. Broader benefits structures, especially for preventive services
4. Enhance provider risk sharing
5. Greater management control over providers and consumers

While some of the key principles just mentioned have been validated, it has been assumed that managed care will continue to grow because of the popularity with insurance carriers, employers, and government as the most effective way to control health care expenditures. What has been overlooked is the effect public opinion and participants in the health care delivery system will have in determining the ultimate development of managed care strategies.

1. The doctor-patient relationship had been altered and has lead to some consumer dissatisfaction with limitations on choice of providers and perceived restrictions of care.

2. The issue of antitrust, particularly as it relates to the formation of provider network or purposes of contracting; and the viability of hospitals, groups and other providers that are excluded from networks.
3. Physician and other professional provider satisfaction or dissatisfaction; contract limitations and requirements, such as utilizations review and other constraints on practice patterns.
4. The strategy of capping premiums does not address the underlying factors beyond inflation that have affected rising health care costs, such as advanced technology and the rising elderly population.
5. Price controls on providers or payers could create inefficient use of resources, premium regulation or rate control is feared by some to lead to rationing of services.

Intervention in the health care system by the federal government may substantially affect the evolution as a result of health care reform legislation (Woldson, J., Levin P.J. Campbell 150-131). In all likelihood, experimentation with managed care is not yet over. While managed care has come a long way, many challenges and uncertainties remain.

CHAPTER II

COMPARISONS BETWEEN MANAGED CARE AND TRADITIONAL HEALTH CARE PLAN

Cooperation between all agents of the health care industry will help finally initiate the changes that have become necessary. These changes may help dissuade doctors from occasionally running unnecessary tests, performing costly procedures and keeping patients in the hospital longer than required. All of these factors have contributed to the increase in health insurance premiums.

Certainly something needs to be done to help contain costs. HMOs were developed for this purpose. The premiums are paid to the HMO by a group or its members. Out-of-pocket expenses are reduced by smaller premium payments. Small copayments and/or deductibles may represent full payment for various health services which have been rendered.

The responsibility for costly procedures is now deferred from the consumer. Membership in an HMO allows recipients to reap full medical benefits without punishing them for the brutal costs of the field's rising technology. The deductible or copayment represents the member's only financial responsibility while accessing medical benefits. The coverage that

follows also blankets preventative care. HMOs place great emphasis on detecting an illness in the early stages, thus saving the money that would have been spent on the prolonged treatment that may accompany a belated diagnosis.

Some of the concerns over this new form of health care have already been expressed. The quality of care is a concern of some members. The reason for this is that HMOs realize a higher profit margin when the amount of medical care is decreased. This problem could be the antithesis of the previously mentioned "over-testing" sometimes associated with physicians.

The goal of an HMO is to keep the present and future costs of health care down. They try to accomplish this goal by performing as a self-sufficient health care provider and giving treatment or service within the HMO network. (Business Horizons 69)

If a member of the HMO needs a particular type of service that is not provided by that HMO, he or she is sent, by referral, to a local specialist or hospital and the fee is paid by the HMO. Since the HMO is responsible for this fee, physicians are urged not to send patients to a specialist unless it is absolutely necessary. This is to keep costs down.

Each physician should also be given a budget to which they are expected to abide by, for outside referrals. They are then compensated

accordingly. The provider who has less outside referrals will be paid more than a counterpart who exceeds the scheduled amount. If a member goes outside of the network for treatment, he or she is responsible for the physician's fee. An exception to this case would be an emergency situation. Again, in order to keep costs down, physicians are paid a flat salary for the year no matter how many patients are seen and no matter how many times a particular patient is treated. In this scenario it is hoped that unnecessary tests and treatments are eliminated. Members are able to visit their physicians as often as they like with only a small visitation charge.

This is not always the case with traditional insurance plans. Traditional health insurance has dramatically changed in the past two decades due to the introduction of the HMO. This new wave of health care has greatly increased the number of options available to employees of large organizations. Prior to the HMO, choices relating to health care such as premiums, physicians and hospitals were severely limited. In the past, most people were only offered the traditional health insurance. This conventional style of health insurance is a form of coinsurance where the employers and employees both pay a portion of the monthly premiums. In the event of illness, the insurance pays about 80 percent of the cost directly to the health care provider (Porter 118). The member is held responsible for the remaining portion of the bill. In this plan, a member is permitted to go to

any physician he or she chooses, without a referral. Following the member's office visit, the physician is paid up to 80% of his or her fee for the treatment. It is up to the patient to pay the physician the remainder of the charge.

Much of traditional health insurance does not cover preventative care. For this reason, many individuals insured by this type of coverage avoid routine check-ups. Such simple precautionary measures are bypassed to avoid costs. In a sense, traditional plans encourage the avoidance of preventative medicine. With health care costs rising through the roof, individuals feel that routine care is unnecessary. People assume that since they are healthy they do not need treatment. Unfortunately, this type of thinking can eliminate early diagnoses and the prevention of long term and perhaps fatal illnesses.

HMO membership does include preventative screening procedures. It is believed that the promotion of healthy living, including such things as exercise, will prevent an illness before it develops. This in turn will save health care costs in the future. Preventative services provided as much as 20% more then the traditional health care plans according to a Hay Group study that was conducted for the Department of Health and Human Services.

Managed care plans are slowly infiltrating the market. Much of this growth is due largely in part to the member's belief that they are receiving better benefits for the costs. They also believe that health care costs are better controlled through HMOs. According to the KPMG Peat Marwick and HIAA surveys, the HMO members do receive more benefits for the cost of conventional plans. However, HMOs may not always be more effective in controlling health care costs. During 1992, HMO membership coverage averaged $148 a month. More than 98% of these members had preventative benefits with an average of a five dollar copayment for an office visit and no deductible. Conventional membership coverage averaged $154; only 36% of these enrollees had coverage for adult physicals and 46% had well-child care benefits with the member being responsible for 20% of the fee and a $200 deductible.

Though HMOs have reduced health care costs to an extent, high costs remain a concern. For example, Appendix C shows the premium increases for conventional and HMO insurance plans from 1987 to 1992. These figures indicate that annual premiums of HMOs increased by 90 percent, and the conventional plans increased by 105 percent.

Providers and insurance companies need to work together in order for any plan to be successful in offering members high quality health care at an affordable price. Although HMOs offer more covered benefits at

lower annual premiums than the conventional insurance plans, HMOs may even be able to work better at lowering annual premiums, because providers and insurance companies are not working as closely as they should be. A physician may be associated with several HMOs, therefore the loyalty to one organization does not exist. Insurance companies have no control over the providers because of the amount of managed care competition. If a provider does not like the rules of one insurer, he or she will join another. Therefore, according to Lairson, a better working relationship between providers and insurers needs to be established in order for HMOs to be successful.

CHAPTER III

EFFECTS OF MANAGED CARE

The health care sector of our economy is growing rapidly. Its proportion of the gross national product (GNP) has steadily increased and now represents 12 percent of the GNP. Paralleling this growth are the pressures for cost control within the system. New legislation and provider payment strategies of managed care plans transfers financial risk to create economic incentives to control cost and service usage. (Grimaldi 12-13)

One of the most important financial differences between hospitals and other businesses is the way in which their customers or patients make payments for the services they receive. Most customers have one type of payment: billed charges. While there may be some flexibility, i.e. volume discounts, the basic payments are the same. The typical hospital will have in effect four or more different payment systems at any given time. Reimbursement arrangements for hospital inpatient and outpatient services can include a number of methods:

- Charges or Fee-for-Service
- Discounted Charges

- Per Diem Charges
- Per case Charges
- Case Rates
- Capitation

Charges: Charges are the traditional and simplest method of reimbursement. They are also the most expensive and least desirable from a payor's perspective.

Discounted Charges: This is one of the most common payment arrangements between a plan and hospital. Under this method, the hospital submits its full claim to the plan which then discounts it by the agreed percentage. A variant to the flat 'discount off' charges approach is to make the discount volume related. Under this approach, the hospital reduces its charges in accordance with a schedule tied to the incremental patient volume generated as a result of the contract with the plan.

Per Diem Charges: A per diem is fixed daily rate charged by a hospital for a designated service or group of services. This too has become a common arrangement between hospitals and plans.

Per Case (DRG): Similar to Medicare's diagnose related groups, a plan can use a per case or DRG approach to pay for inpatient care. This method of reimbursement assumes the hospital had the ability to control the length of stay on a case by case basis.

<u>Selected Case Rate:</u> This approach is used to address certain categorizes of procedures and negotiate special rates such as in obstetrics.

<u>Capitation:</u> Capitation arrangements may sorted according to the scope of covered services, the degree of risk assumed and the certainty of the payment amount.

The scope refers to the bundle of services covered by the capitated payment. The degree of risk refers to whether the capitated amount is fixed and known before the contracts are signed (Grimaldi 12-13).

Increasingly hospitals are being approached by managed care plans to contract using capitation as the method of reimbursement. This is particularly true when the hospital has formed a joint venture entity. Under this approach, the hospital is paid on a per member per month basis to cover all, or a defined range of inpatient or outpatient services for a defined population of members. Capitation is also applying to other health care providers (e.g. primary care physicians, home health services) and suppliers of managed care organizations. (Grimaldi 12-13)

A capitation payment can be global or partial. An arrangement is considered global when it applies to inpatient, physician and other outpatient services ordinarily covered by conventional insurance policies. Partial capitation arrangements apply to subsets of services, such as all necessary hospital inpatient acute and infusion therapy services and products. Partial

capitation arrangements are growing with health care providers as they attempt to retaining and expanding market share. (Grimaldi 12-13)

A managed care organization may except full or partial risk for some or all capitated services. "Full risk" means that a plan is liable for the total cost of providing covered services to its capitated members. Partial risk means that the MCO is at-risk for only a portion of the cost and its contracting providers have the remaining risk. (Grimaldi 12-13)

It is important for health care providers to have a clear understanding of the services and products that are covered by the capitation rate to ensure not being placed at too much risk, to the detriment of the business. Unexpected increases in costs will not usually be the basis for renegotiation. Ideally, the cost accounting system should define the incremental costs likely to be incurred compared to the incremental revenue to be received. (Grimaldi 12-13)

From the plan's perspective, the advantage of capitation is that hospital costs are predictable and the risk for those costs is effectively passed to the hospital. The hospitals in effect have become a full partner in controlling utilization (The Insiders Guide to Managed Care: A Legal and Operational Road Map, 8, 1990). In all instances, the marketplace will affect the amount that a managed care organization will contract, especially in markets with a large number of surplus beds and underemployed

physician. (Grimaldi 12-13)

The Associated Press reports that to reduce the high cost of health care the insurance companies need to have a pricing freeze on their premiums. When it was reported that the task force was considering price controls on all phases of health care, the health care industry and others came forward. The response from the health care industry was as follows:

> Proposals being considered to freeze the cap of insurance premiums would pose a serious threat to the financial integrity of health insurance companies. (Clinton Administration Floats Health Care Plan, 13) If premiums set by the government were not sufficient to cover the cost of medical care services required by our subscribers, the insurance companies would not be able to pay their claims. (Clinton Administration Floats Health Care Plan 13)

Reasons for the rising cost of health care does not only lie within the health insurance programs, but also with physicians, hospitals, pharmacy and other health facilities. If costs from these different organizations can be regulated then the insurance companies will not be forced to increase premiums. If the premiums for health coverage are lower, then perhaps more consumers could afford individual policies offered by insurance companies, or small businesses could offer health coverage for their employees at an affordable rate.

There should be options. Small employers just will not be able to afford what the big employer has been providing for a long time (Clinton

Administration Floats Health Care Plan 13).

The HMO concept is actually a reversal of the traditional economics of medical care. Since an HMO is bound by a fixed income (the members premiums) and guarantees to provide a broad range of services, it has a strong incentive to use its dollars wisely. Since the physicians who participate in an HMO are compensated by payments fixed on the annual budget, there is less incentive to provide medically unnecessary services and greater incentive to handle medical problems in the outpatient setting, when appropriate.

This does not mean all physicians who work in private practice or fee-for-service basis overtreat; however, studies show that their patients use the hospitals more often, and the hospital cost is the chief contributor to the rising cost of the overall medical care (Lairson 67-69).

> Successful HMO's accept a continuing responsibility to their members and operate on the principle that the most appropriate care is the most cost-efficient. (Lairson 67-69)

Basically, HMO's save money by minimizing the use of hospital beds. HMO's do not provide less health care, they simply shift the emphasis from inpatient to out-patient care and attempt to keep their members as healthy and happy as possible.

The United States increase in hospitals cost have far out-paced the economy's inflation rate. From 1980 through 1989, hospital operating costs increased sixty-three percent above the general inflation rate. For example, the hospital cost growth peaked in 1976, at an inflation adjusted annual rate of nine percent. The measured rise in cost largely results from innovation in medical technology intended to improve patient care (Blankenau 3).

Competition among hospitals and methods of reimbursement provide incentive for the rapid adoption of technological advances (Hospital Cost, 1). Hospitals do not compete for patients, they compete with other hospitals by offering the patients the most updated treatment available; this causes the cost to increase rapidly. In addition, physicians are not rewarded for choosing less costly alternatives (Health Care Spending 2)

In the United States, employers who provided health coverage for their employees in 1991 spent $3,605.00 per worker, on the average, for a total of $196 billion. The typical company's medical bill equals forty-five percent after tax profits. In Missouri alone, Missourians spent approximately $2,805 million per worker on personal health care, and this alone would help control rising health care (Smith 88).

Between 1970 and 1990, the share of the national income grew by almost half again from seven percent in 1970 to twelve percent in 1990; and by the year 2000 projections are that the share will probably exceed sixteen

percent. (Hoffman 70)

One sector of the population showing particular concern over the aforementioned problems would be the elderly. Money reserves appear to be dwindling and resources for the aged of the future could be severely depleted. Therefore, managed care plans can provide the necessary benefits for the increased numbers of elderly people who are more frequently in need of high priced health care. Just as managed care arrangements combine inpatient and outpatient services, HMOs accept total responsibility for their members, even after a patient has left the hospital. Since follow-up care is incorporated in the managed care package, the chance of a patient returning to the hospital due to a relapse of the same illness can be greatly reduced. They also have a predetermined schedule. This schedule tells patients and their families which treatments and services are covered and which ones the HMO will not pay. (Enthovan 39)
Thus, the amount that a patient owes is never a surprise and the possible money problems may be worked out before the bills arrive. Ultimately, complex paperwork should be greatly reduced. Members are not billed for services that are covered by the HMO, the providers and the facilities are billed directly. The only payment the patient may encounter is a small copayment, which is a negotiated fee between the HMO and employer (Enthovan 39).

The allure of HMOs can also be realized by younger consumers. This form of health care can be confusing, especially with its many plan stipulations. However, younger employees can see the advantage in the decrease in out-of-pocket expenses. On the other hand there are some older employees who may be reluctant to change. In many instances, the traditional plan they have been covered by remains their choice despite a greater out-of-pocket expense when benefits are sought. This creates an interesting dilemma considering many older consumers are in more frequent need of health care. (Enthovan 39)

With the larger percentage of consumer responsibility present via the traditional plans, this sector of employees is hit particularly hard by the rising cost of various health services. This can become evident to the consumer who has an allegiance to a particular physician or providing facility. The HMO plan reduces the list of providers to choose from and may not include the preferred provider of choice. However, to exercise the full benefits of the HMO health plan, the consumer must now either pay more out-of-pocket or choose new providers. This can be a problem for many members.

The consumer, in many ways, can have HMO coverage by default. Most employers do offer a choice, but because the employer usually presents the various health insurance packages to the employees, they are

in a position to "sell" the type of insurance policy that will be more beneficial to the company's health care budget. For example, an employer may contribute funds to the less expensive health plan resulting in lower premiums for the employee if he or she elects this particular option (Blankenau 31).

> "Many employees would choose the most cost-effective plan if it were presented in a simplified, consumer reports-style format," says Robert Blendon, P.H.D., a professor at Harvard University's School of Public Health. (Blankenau 32)

Although employees who elect the less expensive insurance policy may have the best value on the premium scale, their decision does not take into consideration the real value of the plan. This is pointed out by Denny Snook, senior analyst for the Federal Employees Health Benefits (FEHB) program at the Congressional Research Services. Even if a health care insurance policy has a smaller premium, it does not always mean a consumer is receiving an equal amount of benefits from that plan (Blankenau 31).

The FEHB should look at more than just the obvious copayment and deductible. A consumer must also know factors such as if their current physician is connected with the HMO to which they are applying. Also, the member and their family must reside in the geographic HMO network in

order to be covered or be able to get in the network for medical services. (Blankenau 31)

Of course when an employee has always used a conventional style of health care, any new option such as an HMO is going to cause some hesitation. Consumers may not know everything they should about their traditional health insurance, but they feel more comfortable with it. Lairson states that if a consumer is open to change and willing to do some research, he or she may realize the positive aspects and built in qualities of an HMO. As stated earlier, the goal of an HMO is cost containment. Therefore, the providers of an HMO have incentive to become involved with their patients early in the treatment process.

> It is less costly to care for a patient with hypertension than to care for a patient with a stroke or heart attack. (Lairson 72)

Second, consumers may see their HMO provider at any time with only a small office visit fee (copayment). For this reason, they are more likely to receive medical treatment on a regular basis, especially at the time their illness begins (Lairson 72).

Another positive aspect of the HMO is their peer review programs which are conducted on both a formal and informal level. In addition, the HMO act of 1973 requires an HMO to have a formal peer review program.

Under the informal peer review program, new physicians, which are elected by physicians already in the HMO, are observed and rated by their peers. Also, all members in the HMO have a medical record that contains every treatment ever done for the patient. These files can be retrieved by any physician or nurse who treats that patient.

Two studies have successfully highlighted some of the built in quality control features of Managed Care. The first was in the November 1967 report of the National Advisory Commission Health Manpower which stated,:

> The quality of care, provided by the Kaiser Permanent HMO system, is equivalent, if not superior to that available in most communities. (Lairson 73)

Consumers must make these choices and are often considered integral in the success or failure with various insurance types. Physicians play just as influential a role. The pay a physician receives may be counterbalanced by the quality of health care he or she provides to their patients. If a physician feels they were is underpaid for services provided, an unethical provider might order unnecessary tests, perform costly procedures, or even substitute cheaper treatments while neglecting to send an ill patient to a specialist.

made aware that they are able to improve the quality of patient care by estimating and upgrading those procedures that most affect the outcomes of patient care. Therefore, a hospital should shift its emphasis from problem identification and treatment to a broader picture of improved quality. This can be done by ensuring that the treatment a patient receives is well coordinated. A hospital should also try to develop new ways to improve the delivery of health care procedures in order to successfully implement this challenge (Blankenau 44).

One hospital in particular, the Memorial Hospital of Rhode Island, revised its strategic plans in an attempt to improve the quality of their patient care. At this hospital, physicians, nurses, and other members of the hospital staff came to an agreement regarding the standard of care specific to the type of illness. These standards were set by a document called care map which consisted of a care map index (CMI) and a critical path (CP). The CMI describes the patient outcome that the staff hopes to achieve. This report is based on the data listed on the CP each day the patient is in the hospital. In this hospital, patient care is shifted from tasks to quality patient care and each nurse is responsible for his or her own patient outcomes during their shift. The care map helps a nurse accomplish his or her goal, because it allows them to compare what is supposed to happen in the care map to what actually did happen while the patient was in the

hospital. Therefore, if a patient is not progressing as expected, problems hopefully can be detected earlier in the treatment process. Any problems that a patient has had in the hospital are recorded in the CP. Therefore, anyone providing care to this patient is aware of the situation and what needs to be done. Over time, the discrepancies which are recorded in the CP of what should happen and what actually does happen may begin to show trends that affect patient outcomes. Then long range plans can be made to improve quality care for many patients. Certain illnesses may even be cured earlier than what is stated in the CMI states. It is at this point that care givers shift their emphasis from problem identification to the quality of patient care, because they have viewed different practice patterns in treating patients and now are able to make quality, cost decisions from them. According to Blankenau, money can be saved on certain illnesses provided treatment and/or tests are recommended early (48).

The figure below is a sample of a care map index of a fractured-hip patient at Memorial Hospital.

Illustration A

TURED HIP

1 of 3

MEMORIAL HOSPITAL OF RHODE ISLAND

PATIENT CARE MAP INDEX

PATIENT'S PROBLEMS	DISCHARGES OUTCOMES	INTERMEDIATE GOALS DATE DAY 1	DATE DAY 2	DATE DAY 3	DATE DAY 4	DATE DAY 5
mpaired mobility	Ambulates independently with assistive device (Specify walker, ______)		Assists nurse in turning side to side	ROM unaffected extremity	OOB -> Chair with assistance - - - - - -	- - - - - - - - - - ->
OUTCOME MET (DATE/SIGN)						
Pain	Pain relieved with oral analgesic	Requests pain med as needed		Pain controlled with PCA or IM med q 3-4 hrs.		Pain relieved with IM narcotics q 4-6 hrs.
OUTCOME MET (DATE/SIGN)						
Pot. Complications R/T Immobility DVT Skin breakdown Constipation Pneumonia Wound Infection	a) Without S & S of DVT b) Skin remains intact c) Normal bowel pattern BM q ______ days d) Lungs clear, RR 12-20/min e) Afebrile Incision without redness, tenderness, swelling	Maintains fluid/ nutritional intake T C DB q 2 hr. WA- - - - -	- - - - - - - - - - Uses IS q 1 hr. WA- - - -	- - - - - - - - - - - - - - - - - - - -	Intake > 1500cc/day -	Maintains/increases weight to baseline - - - - - - - - - ->= - - - - - - - - - -> Lists S & S of Infection Fever Pain Drainage
OUTCOME MET (DATE/SIGN)						
Potential Bleeding R/T Anticoag Rx	Hemorrhage prevented through early recognition of S & S of bleeding				Lists S & S to report: Palpitations SOB Evidence of blood Variations in pain	
OUTCOME MET (DATE/SIGN)						
Self Care Deficit Bathing Toileting	a.) Performs ADL's with assist b.) Toilets independently				Performs ADL's with assistance Requests help as needed	Uses commode at bedside
OUTCOME MET (DATE/SIGN)						
Anxiety	Verbalizes anxiety Participates in care	Identifies plan of care/expected hospital course after instruction			Verbalizes concerns to RN- - - - - - - -	- - - - - - - - - ->
OUTCOME MET (DATE/SIGN)						

1990

Figure 1. Sample of care map index for the fractured-hip patient.

Source: Memorial Hospital of Rhode Island

The case of Memorial Hospital exemplifies a situation where hospital caregivers work closely together in order to deliver quality care to their patients. This hospital would appear to be an ideal arrangement for managed care recipients by concentrating not only on solutions, but also on preventive care (Blankenau 48).

This type of fully integrated health plan provides a glimpse into the future at what could be the most prevalent and successful form of health care. Perhaps for future health care plans to be successful, they might have to mimic the example set by Memorial Hospital. In order for this type of situation to be successful, all parties will have to cooperate, hospitals therefore may have the key role. Indeed a compromise will have to be reached by both sides. Beyond that, sacrifices will need to be made by all parties for a successful system to come into effect. For example, hospitals will need to accept managed care regulations which call for shortened patient stays, limited referrals and the combining of the doctor's fee with the overall hospital charges. Physicians will have to overcome their fear of being financially tied to a hospital and make some exceptions of their own. Many physicians seem willing to try to make some changes that could have positive long term effects.

Hospitals are working to try to encourage physicians into a relationship organization between the two entities. These Physician

Hospital Organizations (PHOs) should represent a much stronger relationship between doctors and hospitals which are bound by a contractual relationship. Many give them the necessary incentives to work more diligently with hospitals towards common goals benefiting both parties (Blankenau 50).

With managed care already in existence and growing, it is important that all providers make the transition into this type of aspect future health care provisions as smoothly as possible. Blankenau states: Hospitals particularly will have to accept managed care as part of their present and future fee arrangements in order to remain competitive with the health care growing market. A hospital affiliated with an HMO not only receives a reduction of hospitalization fees, it has also expanded its business horizons. For example, a hospital may contract with an HMO for diagnostic ancillary services. Then the hospital has become involved with a business of commercial diagnostic sales (Blankenau 50).

Although Blankenau feels that it is very beneficial for a hospital and its staff to accept HMOs, it may be very difficult. Physicians who are affiliated with the hospital may feel that the HMO and its physicians are invading their territory, because the HMO governs primary services and referrals if a member needs specialty care. In addition, the physicians without a contract with the HMO may lose patients, thus leaving ill feelings

programs are essential to cutting costs and allowing expeditious processing of reports and billing (Blankenau 55).

CHAPTER IV

GOVERNMENTAL INTERVENTIONS OF SOCIAL BENEFITS

Numerous proposals have been introduced in the United States Congress and various state legislatures relating to health care reform. Among other things, some proposals, if enacted, could among other things, restrict a Company's ability to raise prices and to contract independently with employers and providers. Certain reform proposals favor the growth of managed health care, while others would adversely affect managed care. Although the provisions of any legislation adopted at the state or federal level cannot be accurately predicted at this time, the management of these insurance companies believe that the ultimate outcome of currently proposed legislation would not have a materially adverse effect on the companies and its results in operations.

Most Companies anticipate this will significantly expand their Medicaid and Medicare managed care products, and as a result will be more exposed to regulatory and legislative charges in these two governmental programs.

Medicare Part A - the Hospital Insurance Trust Fund, which covers in patient hospital care and follow-up services, will spend more then it collects in taxes next year. If nothing is done by the year 2002, the trust fund will be completely depleted.

With the emphasis on controlling costs, developmental efforts will focus on those markets and opportunities which promise the highest return on companies investments. The Medicare and Medicaid products are a new key market for 1996.

HMOs contract directly with HCFA to provide Medicare covered services and other benefits to Medicare eligible individuals in their service area in return for a fixed monthly payment from HCFA for each member. Medicare beneficiaries who join Medicare managed care plans continue to pay the monthly Medicare Part B premium, which is usually deducted from their monthly social security check, to receive Medicare covered services. Additional benefits, such as preventive care, prescription drug, vision, hearing and dental services, are also offered by most HMOs for little or no additional monthly premium. Many Medicare managed care plans have eliminated the Medicare deductibles and coinsurance that beneficiaries have traditionally paid under the Medicare fee-for-service system.

The new Medicare product provides much broader coverage than basic Medicare covered services and offers a wide range of additional

benefits. In return, members must agree to use that insurance plans network of participating providers except for emergency or urgently needed care.

Medicaid is a state-operated program which utilizes both federal and state funding to provide health care services to low-income individuals. An increasing number of states have approached the Health Care Financing Administration (HCFA), the federal agency responsible for the administration of Medicaid and Medicare programs, to request Medicaid waivers that would allow them to establish statewide or local Medicaid managed care initiatives. HCFA mandates that Medicaid managed care plans meet federal standards and provide services that cost no more than the amount that would have been spend on a comparable Medicaid fee-for-service basis.

The current national Medicaid market consists of more than 35 million eligible indiviuals and continues to grow. In an effort to expand access to high quality care while controlling costs, many states have established programs encouraging Medicaid beneficiaries to join HMOs. In fact, several states have obtained waivers from federal Medicaid rules allowing them to expand coverage to the uninsured or to make Medicaid benefits available only through HMOs. Medicaid programs represent an excellent opportunity for insurance companies to rapidly increase HMO

membership, especially in states with mandatory enrollment. In 1996 all accepted insurance companies plan to introduce Medicaid products in all of its existing markets.

CHAPTER V

CASE STUDY

The following case study is based on information obtained from a large mid-Western facility hospital. The statistics are based upon two similar cases where each patient was admitted for maternity services and delivered a healthy child. Only the mother's expenses are compared; these vary slightly, mostly due to a difference in admission dates.

CASE #1

Patient A was admitted in May, 1992. She stayed in the hospital for three nights. Her coverage was paid by her husband's plan. The insurance plan was a traditional form of health care coverage. A breakdown of the charges and payments is listed below (see Appendix A for bill):

Total charges	\$3,378.50
Insurance payment	\$2,623.60
Patient balance	\$ 754.90

80% of the total charges were covered, less some non-covered patient convenience expenses.

CASE #2

Patient B was admitted in August, 1993. She stayed in the hospital for three nights as well. The insurance provided was also group coverage through the patient's husband. This insurance plan was managed care plan that was under contract with this provider. A breakdown of the charges and payments is listed below (see Appendix B):

Total charges	$3,882.80
Insurance payment	$2,232.00
Provider discount*	$1,570.80
Patient balance	$ 80.00 (non-covered convenience expenses.)

* write-off is based on the contract between the insurance and the hospital. This particular case was covered under per diem clause, which allows for a specified amount of payment per day. Payment coincides with the contracted rate for this type of service.

In this comparative analysis, Patient B (managed care patient) clearly experienced larger savings. Although this sample was selected at random the information cannot be construed as indicative of all similar hospital cases. However, the author feels it is a fair summation of the types of benefits available through managed care plans if all regulations are adhered to by the patient.

These two cases and the financial elements presented are intended to show the positive elements involved with a managed care plan benefit when plan regulations are followed by a member.

CHAPTER VI
AMERICANIZED HEALTHCARE

If a system of socialized medicine is not the cure for American medical woes, then what is? Many other ideas have been presented and discussed by our leaders, but it is difficult for the government or the population as a whole for that matter to agree on any specific plan. It may be that America is looking at the dilemma from the wrong angle. The only solution may be a totally new way of thinking about the problems involving medical care. A trend towards preventing disease through primary care physicians might partially eliminate the problem. This, along with better regulation of doctors' wages and more corporate involvement may be among the best solutions, all of which represent some facet of managed competition. These solutions could assist in the handling of the ever increasing problem of rising health care costs.

Prevention of disease through increased primary care could greatly reduce the cost and frequency of medical visits. According to Anthony Robbin, M.D., "Primary care alone can provide more than 90% of the service people need." (Lightfoot 59) He also blames the current financial situation on the backward thinking of many physicians and administrators:

> The cost of preventing the most common and
> costly cause of death, disease and disability
> is small compared with what is spent on treatment
> today. Limiting access to such care does not reduce
> expenditures. On the contrary, it means that the sick
> get sicker, require more expensive hospital care and
> ultimately cost society more. (Lightfoot 59)

"Our mission must be keep people healthy and out of the health care delivery system," agrees Donald Lightfoot (60). Opponents of this idea will argue that primary care cannot possibly stop all diseases before they become serious. However, if a majority of illnesses, or even some of them, are discovered before they reach a late stage, then at least some of the majority of payments can also be avoided. (Lightfoot 59)

In addition to keeping people out of the doctor's office, price regulations would also help control medical expenditures. A study was performed by Harvard economist William C. Hsiao in hopes that a relative-value scale, a scale measuring services by the amount of resources used, could be developed. The findings of the 1988 study indicated, according to Hsiao, the current charges are not in close correspondence with resource costs. (Congressional Quarterly Weekly Report 2713).

What this means to patients is that in many cases they are being overcharged. In 1983, $38.2 billion was spent on excessive physicians' income. Under the prevailing system, some doctors, mostly surgeons and

those who carry out profitable tests, were overcharging Medicare by as many times as could be justified (Congressional Quarterly Weekly Report October 1, 1988). If these payments could be regulated, medical care would become more available because it would be more affordable. Some officials argue that this would do nothing to help the poor or elderly. However, Medicare and Medicaid would also have to pay out less of its allocated budget to doctors as payment. In 1989, more than a quarter of the Medicare/Medicaid budget went directly to the doctors. This would leave more to be spent on patients, thereby increasing the effectiveness of government programs for the poor and elderly. It would also support primary care because fewer expensive services would be performed if they were not profitable, making primary care the main form of medical care.

Corporate America could also help to reduce medical costs and decrease the amount of sickness through employee insurance and general employee fitness. The installment of an employee insurance plan in all businesses would insure that almost every American was covered by Medicare or Medicaid. Because they feel that Socialized Medicine is not the only solution, Congress has already acted towards insuring America's work force. A new bill is in the works which would make all businesses with more than ten employees provide health care (St. Louis Post-Dispatch, 1B) There is one major drawback; that the program would cost

approximately $27 billion dollars. This seems like an incredible amount until compared to the hundreds of billions of dollars a conversion to socialized medicine would cost. (Grimes 1)

Some of this cost could be offset through the employee fitness program. "In theory, by altering the lifestyles of employees and their families, many illnesses and accidents could be avoided, thus saving employers a significant portion of their insurance expenses (Lightfoot, 59). Many employers have installed such fitness programs.

The Wellness program, designed in 1982 with several health care carriers, targets the cause of 50% of workers compensation and 25% of health claims. (minor injuries to the torso, especially the lower back) Donald Lightfoot, a member of the International Foundation of Employee Benefit Plans, sings the programs praise:

> It is simple flexibility stretching regimen for businesses and home, which has proven to be successful in reducing injuries....Results have reduced workers compensation cases and health claims are expected to decrease also. (Lightfoot 60)

This type of program, along with employee health insurance, would act as a double-edged sword in the fight against medical costs.

Dr. Robbins sums up the current medical situation best by saying: "The evidence is in. Prevention and primary care are the only sound long-term ways to remedy excessive, unnecessary spending on medical care. Prevention and primary care make sense for cost containment-now " (Robbins 158). This is what managed care is trying to do, and as Dr. Robbins put it, "now"!

President Clinton's plan, revolves around managed competition and focused on the ideas that have been presented here. Even if his Health Care reform plan were to ultimately be put in place we must be careful not to lose the strengths of U.S. care as it exists today. Much of the success of American medicine can be contributed to two areas. 1) the medical professionals in the United States are by far the best trained and most knowledgeable in the entire world, 2) if health care reform is enacted, which seems fairly imminent, it will affect the doctor greatly. The restrictions on who a patient can see, as well as which patients doctors can treat, has angered many physicians. Also, some physicians feel that by limiting the amount that an HMO will pay to a doctor for each patient does not foster a relationship based on patient advocacy. If a doctor feels that a patient needs specific treatment, but his/her provider (HMO, government funding) does not include it in their plan, then the doctor is helpless. Ultimately, physicians want to be able to determine what type of treatments

best suit their patients. This may in the long run affect the number of students who enroll in medical school and subsequently degrade the quality of physicians and the type of care to which this country is accustomed. This important part of the managed care network requires some close scrutiny and perhaps a few modifications.

Finally, the technology which is pushing cost of care higher yearly is also the same technology responsible for much of the quality of the current health care. While nothing can replace the doctor as a diagnostic tool, much of the recent advances in technology are welcomed accessories. The key to cutting cost while maintaining quality, inevitably by the use of technology, is prudence. Physicians must be able to determine, free of outside pressures such as malpractice, when to use technology. If it is used as a true tool to aid diagnosis or treatment and not as a safeguard against legal action, we will then see costs level off while the quality of care will not be affected.

With these precautions in mind, this country must forge ahead with health care reform. Such drastic, quick change will not be easy. But, with the country's economic future at stake, there must be an active road taken to provide health care reform for everyone, regardless of their financial status. In the author's view, reform makes sense morally and economically and its time has come.

CHAPTER VII

CONCLUSION

The idea that has been given the most consideration by those in Washington D.C. is Socialized Medicine. According to Webster's Dictionary, Socialized Medicine can be defined as:

> medical and hospital services for the members of a class or population administered by an organized group (as a state agency) and paid for from funds obtained usually by assessments, philanthropy or taxation.

In the United States, this would mean that the government would have control over almost all aspects of medical care. The goal of the system would be to provide medical care to all citizens, especially those who cannot afford it at present. This type of program has met mixed reviews, but support for it is growing as the health care problem gets worse. Arnold Relman, editor of the New England Journal of Medicine, believes, "We urgently need a new and more comprehensive approach to health policy..." (Goffman 293).

The former Surgeon General, C. Everett Koop thinks otherwise. "We need a profound change across the board in the way we make medical and health care available to all our citizens," he states. But he adds, "I do

not favor totally scrapping the system we have now.". Though many agree that the current medical system is ineffective, Socialized Medicine might not be the best solution: Alternative methods of health care must be considered.

The major advantage of a government medical system would be equal health care for all people regardless of their financial situation or age. Currently, the poor cannot always afford to seek care. According to Ethan Goffman, "Ballooning costs discourage low-income patients from seeking timely preventive care. So their diseases are treated at a late stage, causing unnecessary suffering and expense " (Goffman 293). In 1983 children from black or white low-income families had only half the chance of surviving the first year of life as children from higher income families (Navarro 80). Proponents of National health care hope that their program would reduce the death rate of the poor so that financial success does not determine life expectancy. The program would achieve this by covering medical payments for every citizen in the United States, regardless of the expense. Only then would health care become equal for all people in the country.

"Reform Health Care" has become the new battle cry for much of the nation. With the state of medical care arguably at its lowest level in history, much of the country has experienced the problem first-hand.

During the most recent Presidential election, President Clinton used the issue of health care reform to gain the support of many of these unhappy voters. During his campaign, he promised to tackle the issue as soon as he was elected to office. The plan was to offer a nationwide healthcare system. But before we as a nation can endorse a plan which provides health care for all, there are some very important questions we must answer.

Three major questions must be answered before support can be expected for a health program for the entire country. First, is a national health care program an ethically-based obligation? Second, can the United Sates government and its citizens afford such a health care package? Finally, will a health care plan which provides for all people be able to maintain the strong points of the current mode of health care delivery? The first question is the most important of the three, although it may be much easier to answer. If we contend that as a nation we can answer affirmatively to the first question, then the second question must focus not on whether the money can be raised, but rather from where it will be raised. The third question may not be answerable until many years from now, long after a new system has had a chance to take full effect.

It would appear to the author that while the ethical side of this issue is the most vital in determining whether or not to provide all Americans

with health care benefits, it is also the most ignored. Some people feel that it is our duty to provide adequate medical care to all, while others feel that health care is a private matter that each person or family must confront. Which opinion a person has depends greatly on their current ability to access health care. Unfortunately, these opinions are often based on how mush, or how little, financial misfortune an individual has had concerning the availability of care. In this author's view this way of thinking must change. Health care, and its result, better health, must be thought of as a benefit to all of society.

If we look at health care from a Catholic perspective, we see that it should be thought of as a basic human liberty, much like those initiated in the Constitution. According to Pope John XXIII, every person should have the right to basic health care. Also, we must look at the overall effect a plan would have on the entire community. If we see that this system would serve the common good of all people, then it is surely an operation worth undertaking (Reilly 6). An overall healthier society would be a benefit to all.

Some of those opposed to a national health care system argue that they would be forced to care for those who do not take care of themselves, for example, someone who is an alcoholic or a chronic smoker. Many are opposed to paying for such a person's health care when that person does not

According to Judith R. Lave, Professor of health economics at the University of Pittsburgh, 30% to 40% of the growth in medical spending is claimed through by the use of technology. Other reasons for the high cost include the incredibly high amount of administrative costs and the high cost of malpractice insurance incurred by doctors, which is then passed on to the patients. A recent study done at Harvard Medical School suggests that $140 billion dollars is spent each year on administration costs and fraud associated with them (Pennar 31). As much as half of a doctor's wages can go to pay for insurance, especially in surgical cases. Much of this expense is then passed on to the patient. Managed competition is trying to reduce this trend. Many times however, doctors may be forced to use all types of technology to avoid costly lawsuits because every possible procedure was not performed on a patient. These are but a few of the many economic problems involved in the intricate system of health care providing.

So, with these cost problems in mind, how does the Clinton Administration and Congress propose to provide health care to all of our citizens while controlling the cost of care. The author feels that the most promising ways to bring health care to all people at reduced cost is through managed competition.

Managed competition is an idea which brings large groups of patients

together, often through an employer, whose business is then bid upon by HMOs and other health providers such as insurance companies. The key idea behind this approach being is to increase market forces because these large groups will have tremendous buying power. The HMOs charge such groups to provide care for a fixed monthly rate which will cover specific treatments. This idea, as discussed previously, is not a new one. In California, an experiment is underway to study the effectiveness of the idea of managed competition. Jerry Hall, a fifteen year veteran of the Oakland Police Department is a member of California's only purchasing alliance. While others in the country have seen their medical expenditures rise by about 12% in the last year, Hall's out-of-pocket expenses have risen by a little over 1%. Hall is also free to choose the group of doctors he will use through his plan. In this case, he has chosen an HMO with specialists to deal with metabolic problems afflicting his children. While Hall's program does not allow him to see doctors outside his HMO, he has so far been extremely happy with the program (Dentzer 66).

Another idea that has been suggested would set what have been termed practice parameters for doctors to follow. However, these guidelines are not designed to override the decision-making ability of the doctor. The hope is that they will reduce costs. By setting these parameters, it would be difficult for a doctor to be sued for malpractice

Another way to decrease cost might be to increase the emphasis on primary care. This country does not have enough doctors trained as general practitioners to treat the nation's population, where a country wide, health care package can be put into effect. The way that the U.S. medical system is run, much of the burden of treatment currently rests on specialists. There may be many reasons for this. As Beck explains, when a medical student graduates from school, his or her average debt hovers around $50,000. Because specialists earn more for their services, many students find this the easiest way to pay back such enormous debts (Beck 64). Many people in the teaching sector of medicine urged the task force headed by Mrs. Clinton to consider allowing students who choose to go into primary care to pay back less of their outstanding debt. By reducing the financial burden, many more doctors may find themselves practicing front-line medicine as primary care physicians. The cost of such an idea would be minimal when compared to the other costs and savings discussed.

Despite the waves President Clinton's reform created, some of it essentially is already in effect. President Clinton was merely trying to refine a system that is beginning to work. The major and most important difference is that he wanted to achieve universal access at reduced consumer cost. Managed competition is and has been effective for a while. Pennar feels that is due in part to "pioneering employers and health providers

across the country." (65)

Unfortunately, the idea that all people can receive equal health care is somewhat utopian. Even in countries which currently have systems of social medicine, the problem of care distribution is not solved. According to a 1983 study performed by Harry Schwarts, PhD:

> Countries with national health insurance invariably resort to rationing schemes which treat people in a discriminatory way and cause long waiting lines for treatment. In such countries, the quality of care declines and medicine becomes more impersonal, more routine and more bureaucratized. (Rowland 88)

Even in Canada, which was viewed as the United States' model for a new health system, the time spent waiting for care is greater than here in America. "While nobody has to worry about paying, you can wait a long time for care," says Carson Beadle, a managing director of Canadian consulting firm William M. Mercer (Faltermeyer 123) What this means for a majority of Americans is that the quality of their health care would decline. People who can currently afford care would be forced to wait on treatment that would be slower and poorer in quality than at present. In essence, the government would decrease the care given to the majority of the country so that a relatively smaller percentage of the population could receive better care. The author feels that is hardly the way to approach the

problem.

The most attractive part of a social medical program would be its ability to decrease the costs of medical care at an individual level. The U.S. currently spends more on health care than any other nation, nearly 14% of our GNP source. That is almost double the amount that Great Britain, another country with social medicine, spends. The average American's out-of-pocket expenditures have also increased. Government officials hope a social system would change this, if the program were funded by taxes. Vincente Navarro, who supports a social system suggests, "a national health program should be based on general revenues coming from income taxes." The reason: fairness.... (Navarro 68). The program would take a percentage of wages, determined by the amount of money the government needed to fund the next year, or by the amount remaining to be paid from previous years. This money would then be distributed to different sectors of the program. By collecting the same tax from every individual, the government would hope to keep all citizens satisfied with the economic aspects of the program.

While the economic aspects of the program seem good on paper, the past should give Americans an idea of the monetary success government control over medicine would have. "Our experience with public schools and public transportation hardly supports the argument that public

ownership promotes equity and generosity (Marmor 161). J. Roy Rowland chooses to get more specific. He asserts:

> Medicare and Medicaid are the closest thing the U.S. has to national health insurance, and the expense of these programs provides the best argument against a more extensively socialized health system. The cost of these programs is expected to reach $141.2 billion by 1992. (88)

The economic burden of the new system seems to be no lighter than the system used now and in the past. "The extra tax burden would be hundreds of billions a year. Such a system has no more chance in the U.S. Congress than a polar bear in the Everglades," says Edmund Faltermeyer. (123) If, or when , the government overspends or runs out of money, certain services will have to be rationed; such is the case in Canada. "Up there the health budget has to compete with the military, highway spending, and everything else." says Carson Beadle (Faltermeyer 130). If this were to occur in the United States, it would ultimately mean higher taxes and poorer care. Both of these situations are exactly what the Government is trying to correct. Again, this is hardly the way to solve the medical situation.

APPENDIX A

PATIENT'S NAME	ACCOUNT NO.	PERIOD COVERED	STATEMENT DATE

BILL TO:	SEND PAYMENT TO:

VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS ACCEPTED
PLEASE COMPLETE CHARGE INFORMATION ON REVERSE SIDE.

PAY THIS AMOUNT	AMOUNT PAID

RETURN TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT TO ASSURE PROPER CREDIT. DO NOT ENCLOSE INQUIRIES WITH YOUR PAYMENT.

PATIENT'S NAME	ACCOUNT NO.

TRANSACTIONS MADE AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT.

STATEMENT DATE	PAGE NO.
10/05/93	4

DATE	SERVICE CODE	DESCRIPTION OF CURRENT ACTIVITY	BILLING CODES	AMOUNT
9/93	003000	PATIENT PAY	-	100.00-

BE YOUR ONLY ITEMIZED STATEMENT FOR THE ABOVE TRANSACTIONS. BUSINESS OFFICE HOURS:
- 4:00 PM. IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT, PLEASE CONTACT:

PHONE:

ACCOUNT BALANCE LAST STATEMENT ▷	3378.50
NEW CHARGES/ ADJUSTMENTS ▷	2623.60
LESS NEW PAYMENTS/ CREDITS ▷	754.90
CURRENT ACCOUNT BALANCE ▷	0.00
ESTIMATED AMOUNT DUE FROM INSURANCE ▷	0.00
PAY THIS AMOUNT	0.00

for tax purposes. This will be your only itemized statement for the above transactions. Additional copies may be obtained for a fee. This statement represents charges services only. Your Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Pathologist, and Radiologist bill separately for their services. Additional patient billing may y for any charges not posted when this bill was prepared.

APPENDIX B

PATIENT'S NAME	ACCOUNT NO.	PERIOD COVERED	STATEMENT DATE

BILL TO:	SEND PAYMENT TO:

VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS ACCEPTED
PLEASE COMPLETE CHARGE INFORMATION ON REVERSE SIDE.

PAY THIS AMOUNT

AMOUNT PAID

NT: RETURN TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT TO ASSURE PROPER CREDIT. DO NOT ENCLOSE INQUIRIES WITH YOUR PAYMENT.

PATIENT'S NAME	ACCOUNT NO.	TRANSACTIONS MADE AFTER THIS DATE	STATEMENT DATE	PAGE NO.

G DATE	SERVICE CODE	DESCRIPTION OF CURRENT ACTIVITY	BILLING CODES	AMOUNT
18/93	295628	IBUPROFEN 600MG	4 AT 3.10	12.40
18/93	296743	TUINAL 100MG	TUNIAL 100MG 100MG,C	7.50
18/93	810054	SPECIMEN COLLECTION FEE		6.75
19/93	296743	TUINAL 100MG	TUNIAL 100MG 100MG,C	7.50
19/93	290393	TYLENOL 325MG	8 AT .10	0.80-
23/93	007000	ADJUSTMENT	SERVICES ON 08/16/93	1,570.80-
27/93	005000		SERVICES ON 08/16/93	2,232.00-

LL BE YOUR ONLY ITEMIZED STATEMENT FOR THE ABOVE TRANSACTIONS. BUSINESS OFFICE HOURS: M - 4:00 PM. IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT, PLEASE CONTACT

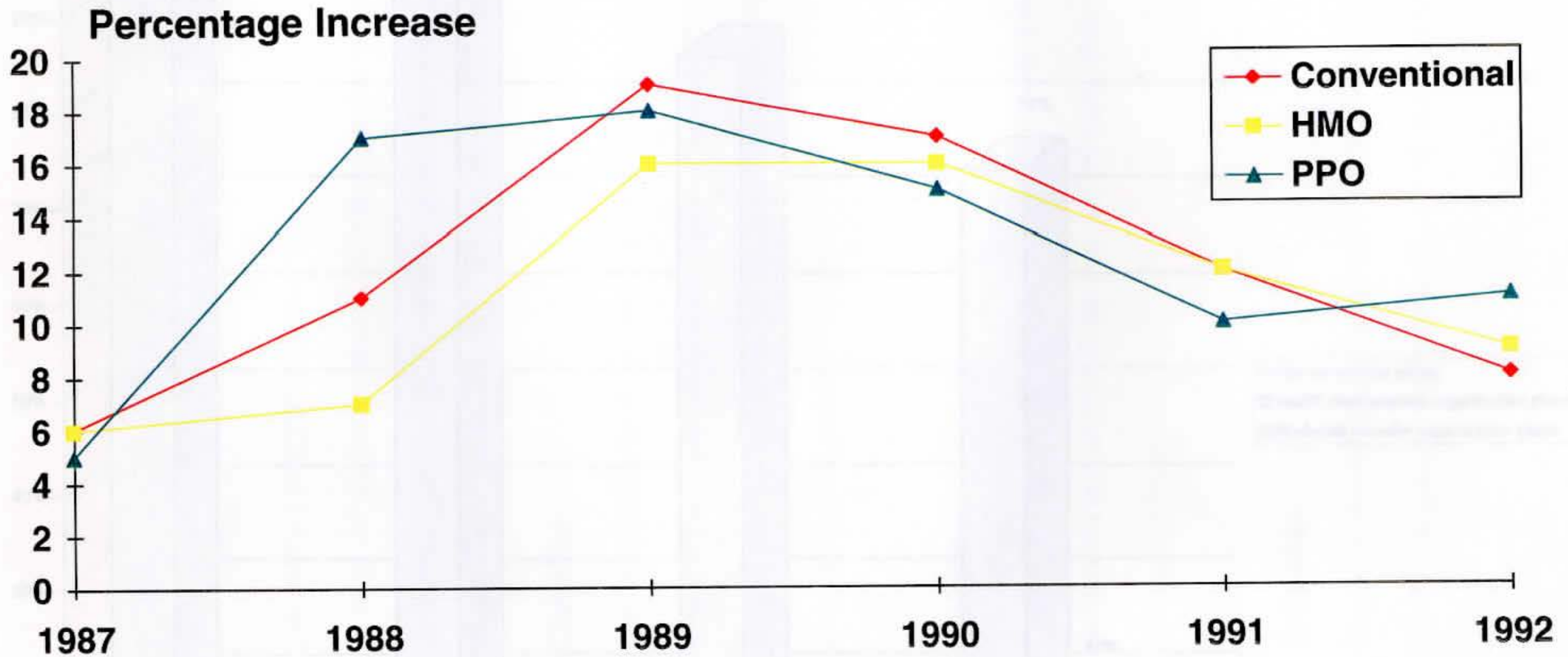
PHONE:

ACCOUNT BALANCE LAST STATEMENT ▷	0.00
NEW CHARGES/ ADJUSTMENTS ▷	3,883.60
LESS NEW PAYMENTS/ CREDITS ▷	3,803.60-
CURRENT ACCOUNT BALANCE ▷	80.00
ESTIMATED AMOUNT DUE FROM INSURANCE ▷	0.00

PAY THIS AMOUNT	80.00

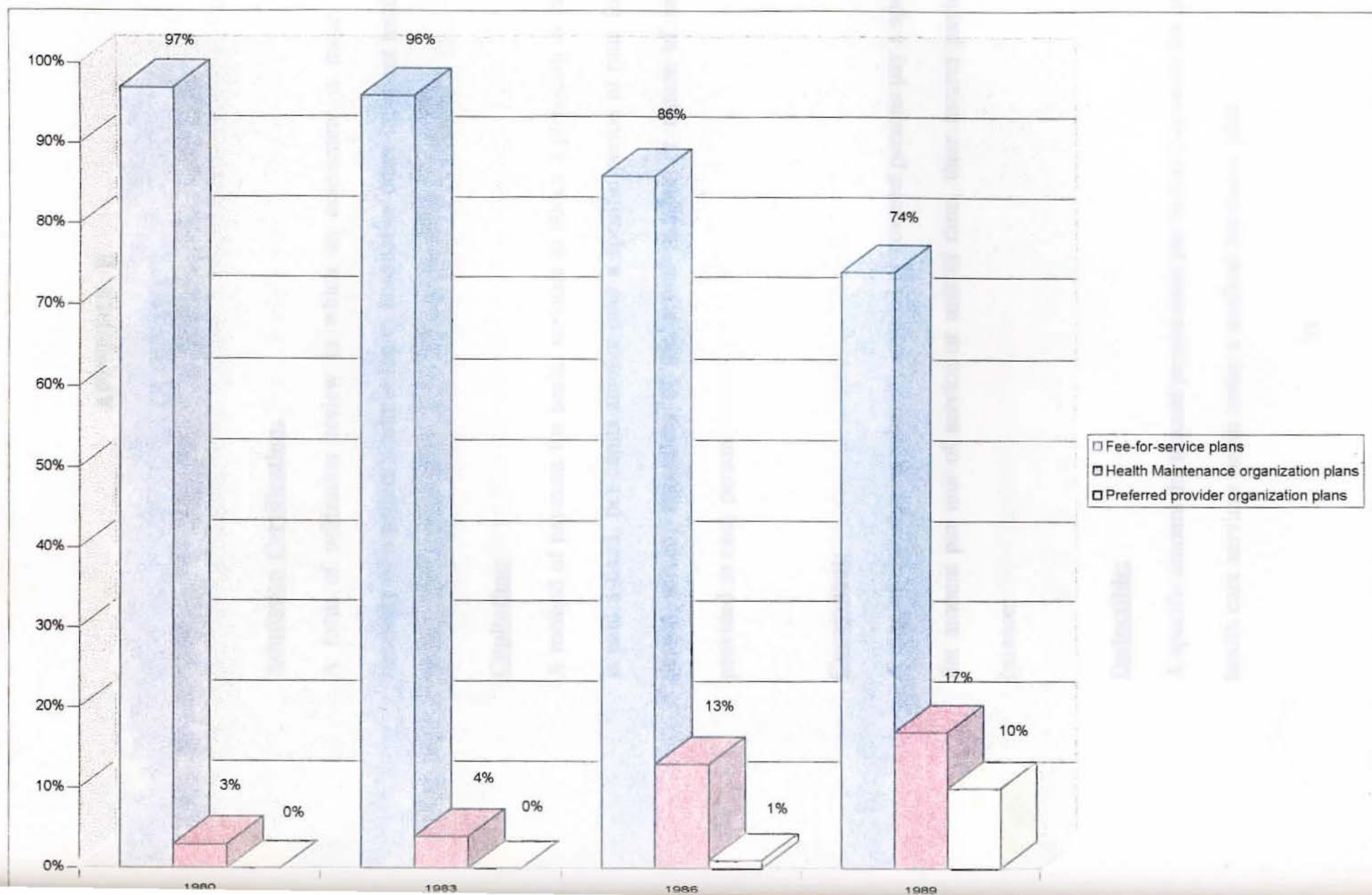
ep for tax purposes. This will be your only itemized statement for the above transactions. Additional copies may be obtained for a fee. This statement represents charges ital services only. Your Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Pathologist, and Radiologist bill separately for their services. Additional patient billing may ssary for any charges not posted when this bill was prepared.

Appendix C



Source: HIAA (1987-90): KPMG Peat Marwick (1991-92)

APPENDIX D



APPENDIX E

GLOSSARY

Admission Certification:

A form of utilization review in which an assessment is made of the necessity of a patient's admission to hospital or other inpatient institution.

Capitation:

A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount over a specific period of time for each person served, regardless of the actual number or nature of services provided to each person.

Copayment:

A type of cost-sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, their insurer paying the balance.

Deductible:

A specific amount the insured person must pay before payments for covered health care services begin under a medical insurance plan.

Exclusive Provider Organization (EPO):

An EPO is a more rigid type PPO requires the insured to use only designated providers or sacrifice reimbursement altogether.

Fee-For-Service (FFS):

Traditional method of paying for medical services whereby a physician or other practitioner bills for each encounter or service rendered.

Group Model:

A type of HMO with medical centers where many different health services are provided in a central location.

Health Maintenance Organization (HMO):

An organization that provides a wide range of comprehensive health care services for a specified group (e.g. government, schools, employers) at a fixed periodic payment.

Indemnity:

Benefits paid in a predetermined amount in the event of a covered loss.

Individual Practice Association (IPA):

A type of HMO in which a partnership, corporation, or association has entered into an arrangement for provision of their service.

Managed Care:

Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care

providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to use providers and procedures associated with the plan.

Managed Competition:

A theory of health care delivery in which a large group of consumers choose among health plans that offer similar benefits: competition is based, therefore, on cost and quality.

Point of Service (POS):

Often known as open-ended HMOs or PPOs, these plans encourage the use of network providers, but permit insured individuals to choose providers outside the plan at the time service is rendered.

Preferred Provider Organization (PPO):

An arrangement with whereby a third-party payer contracts with a group of "preferred" medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain column of patients.

Primary Care:

The point when the patient first seek assistance form he medical care system: also the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and treatment.

Staff Model:

A type of HMO, similarly to the group model, in which physicians are salaried employed who provided their services exclusively to HMO enrollers.

Utilization Review:

A mechanism used by some insurers and employers to evaluate health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include pre-admission certification, concurrent review with discharge planning, and retrospective review.

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