



# **The U.S. Health System: A Primer**

**amsa<sup>®</sup>**

**A publication of the  
Legislative Action Committee  
American Medical Student Association  
1996**

## What is AMSA?

The American Medical Student Association is the largest and oldest independent association representing physicians-in-training—from premedical students to residents. Founded in 1950 to provide an opportunity for medical students to participate in organized medicine, AMSA began as the Student American Medical Association (SAMA) under the auspices of the American Medical Association (AMA). In 1967, AMSA formally ended its affiliation with the AMA and has since remained an independent organization governed by a student Board of Trustees. Much of the association's energy is focused on reforming the medical education system and developing physician leadership for the 21st Century. The Board of Trustees is charged with implementation of the policies and principles established by the organization's House of Delegates at AMSA's annual meeting each spring. With a membership of approximately 30,000 medical students from 142 medical schools, as well as premedical students, interns and residents, AMSA continues its commitment to improving medical training and the nation's health.

### *AMSA's Mission Statement*

The American Medical Student Association is committed to improving health care and health-care delivery to all people; promoting active improvement in medical education; involving its members in the social, moral and ethical obligations of the profession of medicine; assisting in the improvement and understanding of world health problems; contributing to the welfare of medical students, interns, residents and post-M.D./D.O. trainees; and advancing the profession of medicine.

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A publication of the  
Legislative Action Committee  
American Medical Student Association

Rob Nordgren & Jane Deng, editors

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## Introduction

It is the last test you will have to take in medical school. The directions read:

“For 100 points, answer one of the following questions:

- A) Explain the mechanisms of congestive heart failure, or
- B) Describe three different types of managed care organizations.”

**W**hile most medical students could answer question A with great proficiency, the knowledge needed to answer question B could potentially have a far greater impact on patient care. As our health care system becomes increasingly complex, physicians are under growing pressure from external forces to change their practice styles. Some of these pressures will force changes that may not be grounded in sound scientific evidence or based upon good clinical judgment. Thus, the savvy physician of tomorrow, in addition to possessing thorough medical and scientific knowledge, must have a working knowledge of health policy in order to navigate our rapidly evolving health-care system.

Although medical school curricula devote variable amounts of time to health policy issues, evidence suggests that this area should receive more focus. For example, an Association of American Medical Colleges survey found that 68% of 1993 medical school graduates felt their education provided deficient exposure to medical care cost control, and 64% felt there was deficient exposure to medical socioeconomics. Furthermore, medical students at AMSA’s 1995 Chapter Officers Conference were asked to rank statements describing their medical education. Respondents from 62 medical schools ranked “The importance of the role of the political process in formulating health-care policy is understood” last of 14 statements that characterized their medical education. Thus, filling the gaps in health policy education is one of the major goals of the Legislative Action Committee of AMSA.

The purpose of this primer is to outline major health policy issues and introduce the reader to basic elements of the U.S. health system. Within these pages you will find concise, lucid articles that outline how our health-care system functions, such as the piece on managed care, along with articles that address broader policy issues, such as the pieces on provider supply or the single-payer system. In addition, you will find references for further reading on all of the topics.

Finally, we want to thank all the people who made this publication possible. The authors are all medical students and active in AMSA. Without their expertise and hard work, we could never have produced this publication. We would also like to thank Nancy Busse and Mary Jo Lawrence, our administrative support in AMSA’s National Office. They spent long hours formatting the primer and have been a constant source of support for all of the Legislative Action Committee’s projects. We hope you find the primer informative—more importantly, we hope you enjoy it!

Rob Nordgren and Jane Deng  
Legislative Action Committee National Coordinators

# Access to Health Care

by Rob Nordgren

Columbia University, College of Physicians and Surgeons and School of Public Health

**A**ccess to health care in the United States is a major public policy issue and often cited as the most significant failing of our health-care system. In 1994, 16.1% of respondents to a survey conducted by the Robert Wood Johnson Foundation (RWJF) reported that they were unable to obtain needed health-care services in the previous year. This figure represents more than 41 million Americans. There are two factors that affect access to health care: ability to pay for services and availability of health-care providers and facilities.

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***In 1994, more than 41 million Americans were unable to obtain needed health-care services.***

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As Drs. Bodenheimer and Grumbach point out in their text *Understanding Health Policy: A Clinical Approach*, “Between the 1930s and mid-1970s, because of the growth of private health insurance and the 1965 passage of Medicare and Medicaid, the number of uninsured persons declined steadily, but since 1976, the number has been growing.” This increase in the number of uninsured is primarily due to a reduction in employment-based private health insurance. The number of Medicare and Medicaid beneficiaries has increased steadily since 1976, while the number of Americans insured through their jobs has declined by over 10 million.

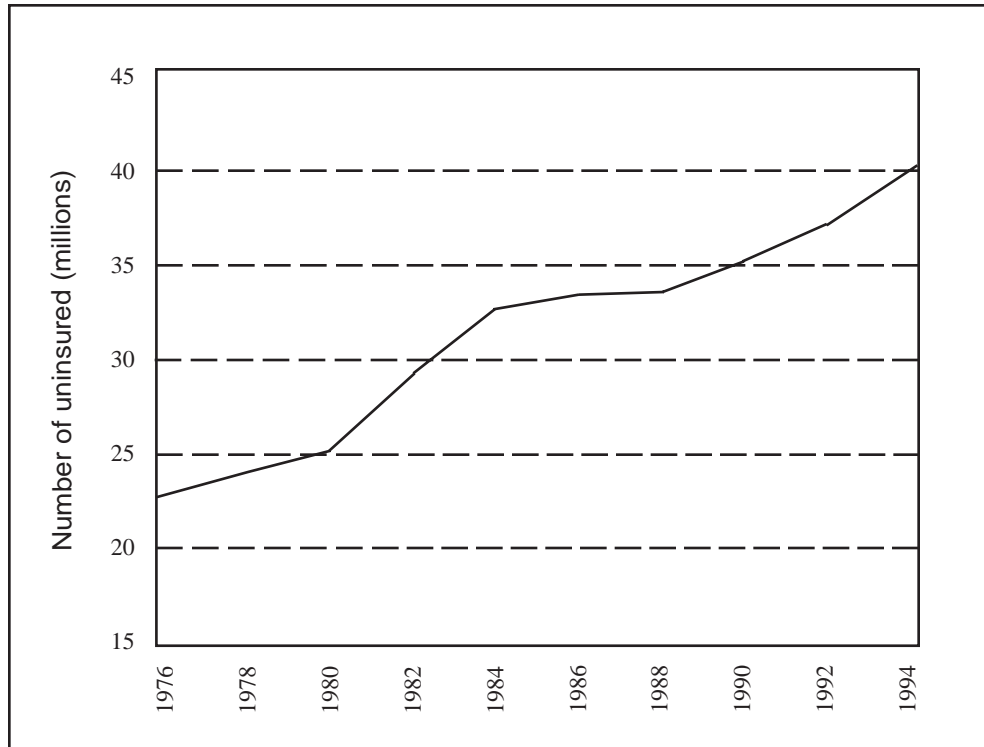
Health insurance is the most important correlate to health-care access; uninsured persons

are two and one-half times as likely as insured persons to have unmet health-care needs. Furthermore, a study conducted by the U.S. Congressional Office of Technology Assessment in 1992 showed that people lacking health insurance receive less care and have worse health outcomes compared to those with insurance. Other factors that play a role in health-care access include household income, and having a usual source of care. More than 24% of those who live in households with an income of less than \$20,000 had unmet health needs, while fewer than 8% of those in households with an income of more than \$50,000 had unmet needs, according to the 1994 RWJF survey.

There are also significant non-financial barriers to health care, including location of health services, gender and race. Studies have shown that those who live in rural areas have fewer physician visits per year than those who live in metropolitan areas. Race can also be a barrier to health-care services. As Bodenheimer and Grumbach point out, at a California emergency room in 1990 and 1991, 55% of Hispanic patients with extremity fractures received no pain medication, compared with 26% of non-Hispanic whites. The difference in treatment was not attributable to insurance status. Gender is also a factor; it has been shown that women in the U.S. receive a less extensive work-up than men with the same medical complaints.

Finally, access to health care is not a one-dimensional problem. While providing insurance coverage for all Americans would improve access, we must also confront other economic, geographic and clinical barriers to care. ♦

**Number of Uninsured Persons in the U.S., 1976-1994**



Data extracted from: Bodenheimer TS and Grumbach K, *Understanding Health Policy: A Clinical Approach*. Appleton and Lange, Norwalk, Conn., 1995, p. 20; and Berk et. al., "Ability to Obtain Health Care: Recent Estimates from the Robert Wood Johnson Foundation *National Access to Care Survey*," *Health Affairs*, vol. 14, no. 3 (Fall 1995), 139-146.

# Academic Medical Centers

by Andrew Sikora  
Albert Einstein School of Medicine

**T**oday's academic medical centers are very nearly all things to all people: training sites for current and future health professionals, providers of health care to the urban poor, centers for the development and application of cutting-edge medical technologies, and "think-tanks" for the exploration of ethical and public policy issues in medicine. But what will

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*Although academic medical centers account for only 18% of the nation's acute-care beds, they provide 44% of all charity care.*

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be the fate of this enterprise as we enter the twenty-first century?

There is compelling evidence that academic institutions will find it increasingly difficult to provide such a vast array of services. The current system is supported by a complicated network of private donations, student tuition, clinical revenues and tax dollars in the form of direct grants for medical research and indirect subsidies. Despite this diversity of funding sources, academic medical centers are currently getting squeezed from several directions at once:

- Federal funding is not keeping up with the pace of medical research, placing a greater burden upon schools to support their faculty directly.

- The movement toward managed care will significantly decrease medical center revenues. In 1991 and 1992, medical schools in the U.S. obtained close to 47% of their total revenues of \$23 billion from medical services. This total will undoubtedly decrease with the shift to managed care, as HMOs direct patients to less expensive nonteaching hospitals instead of academic centers.

- Reduced support of Medicaid has decreased clinical revenues in many academic medical centers. State cuts in Medicaid, along with the drop in federal matching funds, are disproportionately hard on academic medical cen-

ters because these centers treat a high percentage of poor people.

- Proposed federal legislation directly threatens the Indirect Medical Education allocation (IME), which sets aside a portion of Medicare revenues to compensate teaching hospitals for their educational costs.

In the meantime, academic departments are faced with a nearly insurmountable "catch-22": while nonteaching institutions are responsible only to themselves, their patients and their local communities, academic centers bear the additional responsibility of developing and disseminating new advances for the benefit of society as a whole. Yet they are subject to the same cost-containment pressures that nonteaching institutions currently face, and—because of the social mission of most academic medical centers—they bear an additional financial burden as providers-of-last-resort for the uninsured. In fact, although academic medical centers account for only 18% of the nation's acute-care beds, they provide 44% of all charity care. Increased efficiency might allow preservation of the academic mission for a time, but at some point it will become impossible to do more with less. This will force academic medical centers (and the citizens they serve) either to rethink their goals or to develop new and creative strategies for funding them.

While academic medicine has a defining influence on the way medicine is practiced, its directions are reciprocally influenced by the changing needs of the population it serves. The teaching mission of large training centers ensures that they will remain staffed by a disproportionate number of specialists and specialists-in-training, but such centers will also be required to fill increasing demands for physicians trained in primary care and community medicine.

As the market changes, we may expect to see some of these shifts reflected in the organization and distribution of academic departments. Changes in the way Americans receive health care have already fueled the rise of fam-



ily medicine as an academic discipline. An increased emphasis on preventive medicine and cost-effectiveness of health care may provide new opportunities in fields such as environmental health, epidemiology and social medicine. Another discipline likely to flourish in the near future is the study of medical ethics. The pace of discovery, while never as fast as we wish, frequently exceeds our ability to interpret the significance of new advances, e.g., what does it mean to be able to predict genetic diseases we cannot yet cure? When does uncertain or borderline improvement justify withholding intervention? These questions, and many more, await answers.

Finally, since even the best medicine is worthless unless it effectively reaches those who need it, the delivery of health care itself will continue to be a subject of intense scrutiny. While the potential for "health-care reform" in the near future is debatable, changes in our delivery system have already begun in haste and show no sign of letting up. The years ahead will be turbulent ones, for better or for worse, and if one of the roles of academic medicine is to be medicine's "eye upon itself," it had better not blink. ♦

#### **Facts**

In 1991 the average cost per admission at an academic medical center was \$6,000, while at a non-teaching hospital it was \$4,400.

In 1960 academic medicine received \$1.32 billion from the NIH, and in 1996 will receive \$11.94 billion.

# Provider Supply and Distribution

by Clara Lee, M.P.P.  
Yale University School of Medicine

**F**or decades, health-policy experts have been arguing that physicians in the United States are poorly distributed. Now, in the context of unprecedented interest in overall health-care reform, policymakers and politicians have begun to focus a great deal of attention on reforming the physician work force. This attention arises out of a belief that the distribution of physicians has a significant impact on access to

physicians per 100,000 persons. Ironically, in the face of these underserved areas, there is a growing perception that we have too many physicians in the U.S. In fact, a recent report by The Pew Health Professions Commission called for the closing of 20% of our nation's medical schools.

Though nearly all health-care reform plans agree that physicians are currently not ideally distributed, they differ in the degree to which they call for government intervention and in the goals they set for redistribution. The most hands-off approach assumes that market forces would be sufficient to bring about any necessary changes to the physician work force. For example, such an approach might assume that rapid growth in managed-care plans would naturally encourage more medical students to choose primary care careers without any need for government regulation. There is evidence to suggest that this may be the case. The percentage of graduating medical students entering primary care declined from 36% in 1982 to 14.6% in 1992. However, in 1995 more than 27% of medical school graduates indicated an interest in pursuing a generalist career. Some observers credit the managed-care environment, or the anticipation of it, for this recent trend.

The most interventionist approach, on the other hand, would call for regulatory changes as well as reform of medical school and residency policies. A more intermediate approach would avoid regulatory changes but would create incentives for physicians and medical students via changes in residency and medical school policies, scholarships and payment reforms.

Policymakers can use a number of levers to change the physician work force. Much of the funding for graduate medical education (residency programs), comes from Medicare payments to hospitals, so Congress can exert control on residency programs by placing restrictions on Medicare graduate medical education funds. Several groups, including the American Medical Student Association, the Pew Commission and the Council for Graduate Medical Education, advocate limiting Medicare funding of

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***Studies of physician availability across the United States have found that the number of areas with a shortage of physicians has been increasing since 1980.***

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health care, the appropriateness of care delivered, and the cost of care.

When policymakers discuss physician work force and distribution in the U.S., two problems are commonly cited: the percentage of primary care providers and the overall geographic distribution of our nation's work force. The percentage of physicians in this country who practice primary care declined from 53% to 33.5% between 1960 and 1990. In contrast to the United States, 53% of Canadian physicians and 59% of British physicians are so-called generalists. Furthermore, studies of physician availability

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***In 1995, more than 27% of medical school graduates indicated an interest in pursuing a generalist career.***

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across the United States have found that the number of physician-shortage areas has been increasing since 1980. While overall physician availability increased in the U.S. by 34% between 1975 and 1985, it increased by only 14% in small rural areas. In San Francisco, Boston and Washington D.C., there are as many as 600 physicians per 100,000 persons compared to Appalachia where there are fewer than 100 phy-

residencies to 110% of the number of U.S. medical graduates in order to decrease the number of new residents, thereby linking the growth in the physician supply. Several groups would also require that at least 50% of residencies funded by Medicare be in primary care fields.

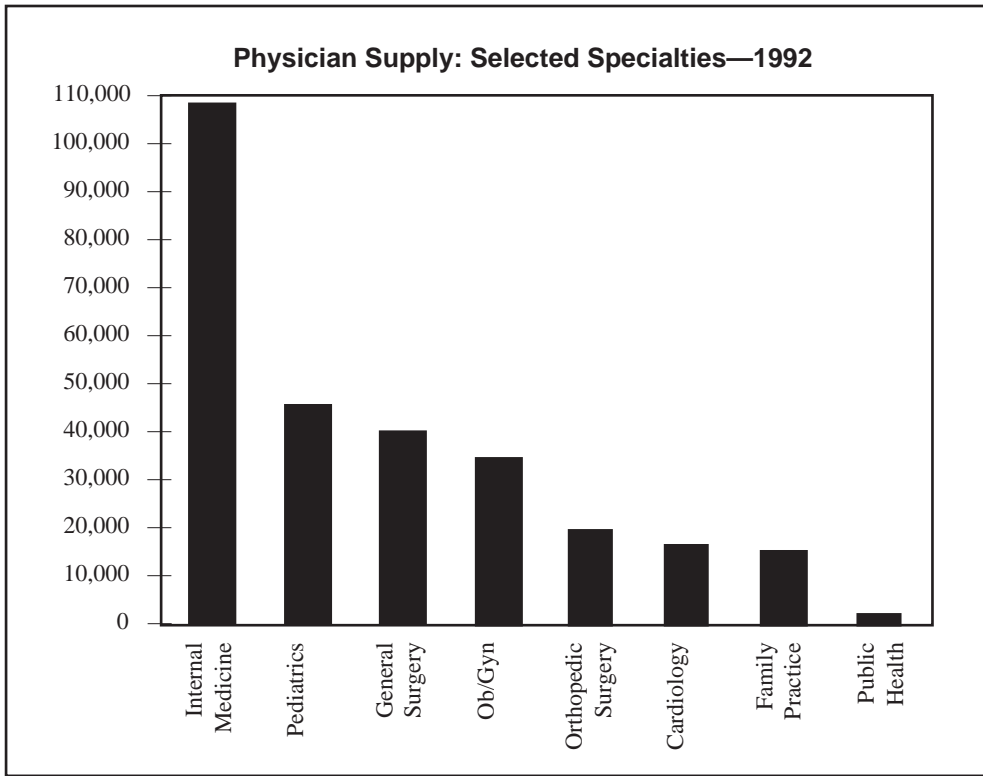
Other policy levers include scholarships, loans and loan forgiveness programs that are tied to commitments by medical students or residents to practice in certain locations or fields. The government can provide inducements to physicians who are already practicing by paying bonuses to those who work in shortage areas, retraining specialists in primary care, reducing administrative burdens for primary care providers, and creating fee schedules that favor more cognitive activities over procedures. States can also attempt to recruit students from shortage areas underserved minorities into medical school, based on the finding that those students

are more likely to return to underserved communities.

Proposals to reform the physician work force raise many new questions for providers, patients and policymakers. For example, what objective data exists to make us think that distribution of physicians has a significant impact on access to care, quality of care or costs? What would be the outcomes, both intended and not, of some of the policies being considered? How much data do we have to help us to predict those outcomes? How politically feasible are those policies? How fair would they be to medical students, residents, foreign medical graduates and practicing physicians, as well as to patients? Critical thinking about these issues by all players, and particularly by physicians-in-training, would inform the future debate and contribute to its final result. ♦

**Fact**

In 1992, the 118,531 International Medical Graduates (IMGs or graduates of non-U.S. medical schools) constituted 22 percent of the total U.S. physician population.



Source: The Agency for Health-Care Policy and Research

# Health-Care Financing

by Shannon L. Udovic  
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The United States spends more than any other nation on health care. In 1993, the U.S. spent \$884.2 billion on health care, a 7.8% increase from 1992. This represents 13.9% of the gross domestic product (GDP), up from 5.3% in 1960.

With such skyrocketing costs of health care, cost-containment has become a major impetus for health-care reform. Proposing meaningful health-care reform requires an understanding of current health-care spending and sources of funding.

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*In 1993, at 56%, private funding was at the lowest that it had ever been.*

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## PRIVATE FUNDING

Private sources of health-care funding include consumer out-of-pocket payments, private health insurance and other private funds. The amount paid for health care by the private sector has shifted in the past 30 years as government funding for Medicaid and Medicare has increased. In 1960, about 75% of health-care costs were covered by private sources. In 1967, the year after the implementation of Medicaid and Medicare, the percentage of private funding decreased to 63%. In the early 1970s, Medi-

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*In 1993, 43.9% of national health expenditures were financed by the government.*

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care began covering disabled individuals, leading to another decline in privately funded health-care costs. In 1993, at 56%, private funding was at the lowest that it had ever been.

Out-of-pocket funds, including co-payments, deductibles and other direct payments, was \$157.5 billion in 1993 and accounted for 20% of health-care expenditures. This had decreased from 56% in 1960.

Private health insurance accounted for 33% of health-care expenditures in 1993. The majority was through employer-based private health insurance. Private health insurance is regulated at the state level and must include certain benefits. There has been an increase in mandated benefits that has led to an increased cost of insurance. An exemption from state mandates and other Employer Retirement Income Security Act (ERISA) regulations is given to large employers choosing to self-insure. The private insurers include commercial carriers, the "Blues" (Blue Cross and Blue Shield, non-profit insurers), self-insurance, and prepaid health plans/health maintenance organizations. In 1993, as employers tried to control costs, managed care accounted for 58% of private health insurance and just 42% was traditional fee-for-service.

## PUBLIC FUNDING

In 1993, 43.9% of national health expenditures were financed by the government, both federal and state. Funding was provided for the following governmental health-care programs:

### Medicare

In 1993, Medicare spent \$154.2 billion covering 36.3 million elderly and disabled individuals. The majority of Medicare expenditures are used to cover acute care services. For example, hospital care accounted for 61.3% of health-care expenditures, or \$92.7 billion, and physician services accounted for 23%, or \$34.8 billion. At the beginning of the Medicare program reimbursements were cost-based for hospitals and fee-for-service for providers, but due to the tremendous rise in costs, changes were implemented. The Prospective Payment System (PPS) based on diagnosis related groups (DRGs) allows funding based on a fixed payment for each diagnosis. In 1992 the physician fee-for-service payment system was replaced by the Resource-Based Relative Value Scale (RBRVS), in which reimbursements are based on a federally set fee schedule determined by the resources used in each type of physician service.

**Medicaid**

In 1993, Medicaid accounted for 30.4% of all public funding. The program spent \$117.9 billion in federal and state funds for 33.4 million people. There has been accelerated Medicaid spending growth due to mandates expanding eligibility and the requirement for higher reimbursement rates. A large portion of Medicaid expenditures funded institutional services with 37.6% going to hospital care and 31.9% going to nursing home care. In 1993, Medicaid paid for 13% of all hospital care and 51.7% of all nursing home care.

**Other governmental programs**

In 1993, 13% of the national health-care expenditures, or \$114.9 billion, provided funding for other governmental programs. These programs included the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Veterans Administration (VA), Federal Employees Health Benefits Program (FEHBP) and Indian Health Services.

The spiraling cost of health care in the U.S. has turned our focus to cost-containment. Thus, we are witnessing major shifts in both private

and public health-care financing. In the private sector, managed care is expanding at an unprecedented rate and businesses are expecting, and often realizing, savings. In the public sector, the federal government has pledged to slow the growth of Medicare and Medicaid. ♦

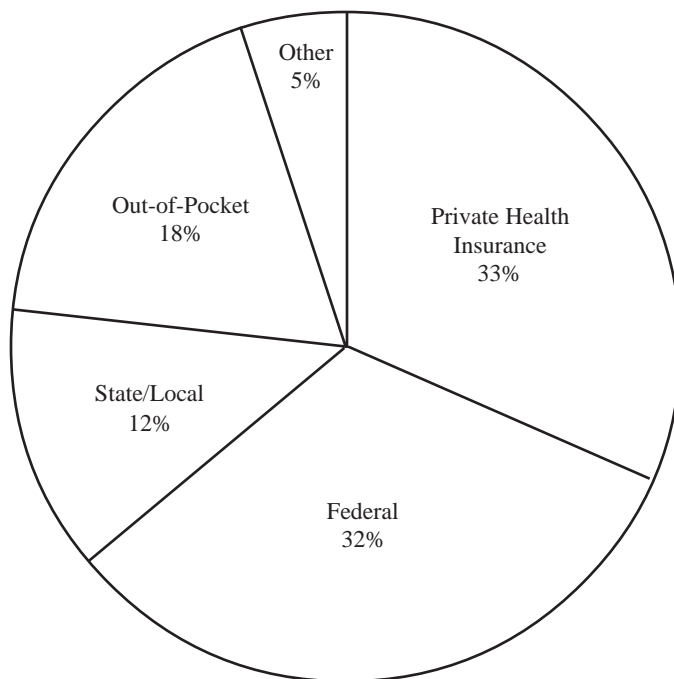
**Definitions**

Co-payment—A fixed dollar amount per service that is the responsibility of the beneficiary. Co-payments tend to be modest and are devices to reduce unnecessary utilization. Critics charge that co-payments reduce access to care.

Deductible—A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. Deductibles range from \$100 to \$2,000.

Fee-For-Service—A system of paying physicians for individual medical services rendered, as opposed to paying them by salary or capitation (fixed fee per patient).

**Sources of Health Care Financing**



Source: U.S. Health-Care Financing Administration: Levitt et al., "National Health Spending Trends, 1960-1993," *Health Affairs* (Winter 1994) 14-31.

# Managed Care

by Lucia Lomotan  
Tufts University School of Medicine

**A**lthough created in 1928, managed-care plans have blossomed in the past decade. From 1985 to 1995, the number of Americans enrolled in HMOs increased from

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*From 1985 to 1995, the number of Americans enrolled in HMOs increased from 18.9 million to 56 million.*

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18.9 million to 56 million. With managed care playing an ever increasing role in our health-care system, it is imperative that we understand how the system works.

“Managed care” is a broad term for a system that integrates the financing and delivery of medical care through contracts with selected physicians and hospitals to provide comprehensive health-care services to enrolled members for a predetermined monthly premium (capitation).

The broad goal of managed care is to contain health-care costs while maintaining quality. How is this achieved? Both utilization review and cost containment features are incorporated into managed-care plans that are de-

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*The basic elements of managed-care plans include selecting providers, regulating clinical choices and directing provider practice patterns.*

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signed to provide care efficiently. The basic elements of managed-care plans include selecting providers, regulating clinical choices and directing provider practice patterns.

First, **selecting providers:** Insurers build provider networks, typically within a specified geographic area. Primary care physicians represent the core of managed-care plans, with specialty care channeled to a small number of specialty providers.

Second, **regulating clinical choices:** The primary care physician acts as a “gatekeeper” and channels referrals to specialists as needed. Medical care is reviewed before and after treatment and/or hospital admission. If deemed inappropriate, payment is not rendered.

Third, **directing provider practice patterns:** Traditionally this has taken the form of appealing to professional standards, while preserving an individual physician’s clinical autonomy. With the advent of practice guidelines, profiling and/or outcomes research can be used to monitor precision of care or compliance with guidelines. Further, there are financial incentives to practice cost efficiency.

Capitation refers to a risk-sharing reimbursement method whereby providers in a plan’s network receive a fixed periodic payment, typically monthly, for health services rendered to plan members. Fees are set by contract between a prepaid managed-care plan and providers to be paid on a per person basis, usually adjusted for age, sex and family size, regardless of the amount of service rendered or costs incurred. If the cost of care exceeds the capitated amount of reimbursement received, the provider absorbs the extra costs. If the provided services amount to less than the capitated payment, the provider retains the excess revenue. The managed-care plan may set aside a percentage of the total annual cap payment in a risk pool to safeguard against unexpected costs. At the end of the year, any money left in the risk pool is returned to the providers. Thus, under capitation, providers assume the financial risk of the potential cost of services and resources utilized in the course of a patient’s treatment. This arrangement has been criticized on ethical grounds because it potentially rewards physicians for withholding care.

Originally, health maintenance organizations (HMOs), preferred provider organizations (PPOs) and traditional forms of indemnity health insurance were distinct, mutually exclusive mechanisms for providing health coverage. Increasingly the distinctions among them have blurred. ♦

### Examples of Managed-Care Organizations

#### **Group Model HMO**

The physician group contracts with an entity that is financially responsible for covering enrollees. The HMO pays the medical groups a negotiated per capita rate which the group in turn distributes among its individual physician members. Examples include Kaiser Permanente and the Health Insurance Plan (HIP) of New York, established in 1947 by Mayor LaGuardia for city employees.

#### **Staff Model HMO**

These grew out of the labor movements in the 1930s and 1940s. Under this system, physicians are employees of the HMO and paid a salary. Examples include Group Health Association (GHA) and Group Health Cooperative of Puget Sound, which emerged at the end of World War II.

#### **Network Model HMO**

The HMO contracts with two or more independent (single or multiple specialty) group practices to provide services and pays a fixed monthly fee per enrollee. The group decides how fees will be distributed to individual physicians. Examples include HealthNet, PacifiCare of California, HMO Illinois (Blue Cross/Blue Shield of Illinois).

#### **Independent Practice Association (IPA)**

The HMO contracts with individual physicians in independent practices, or with an association of independent physicians, to provide services at a negotiated rate per capita, flat retainer or negotiated fee-for-service (FFS) rate to HMO members. Physicians maintain their own offices and see patients on a FFS basis, while contracting with one or more HMOs. Examples include US HealthCare and Blue Choice (BC/BS of Rochester, NY).

#### **Preferred Provider Organizations (PPOs)**

These developed during the 1980's and represent a combination of standard FFS indemnity plans and HMOs. Typically, PPOs are organized insurers, sometimes providers. PPOs have contracts with networks or panels of providers who agree to provide services and who receive payment per a negotiated fee schedule. Enrollees suffer monetary penalties for receiving care from nonaffiliated providers, but that option is available.

#### **Point of Service (POS)**

This is an open-ended HMO or an HMO-PPO hybrid. In this system, there is a network of participating providers. Employees select a primary care physician who determines referrals. If an enrollee gets care from a plan provider, he/she pays little or nothing out-of-pocket, as in an HMO, and does not file claims. Care provided by an out-of-plan physician is still reimbursed on a capitated basis, but usually there are financial disincentives to avoid overutilization. Thus there is an incentive to use certain providers, but enrollees can go outside the system, incurring greater cost. An example here is Allied Signal, Inc.

# Quality Assurance and Utilization Review

by Jane Deng  
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## Quality Assurance

In the increasingly competitive medical care marketplace, an essential administrative activity of any health-care plan is quality assurance (QA). Quality assurance is “a formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies.” (PPRC, 1995) Managed-care organizations, in particular, have undertaken QA activities with great gusto, as cost-containment and provider incentives to undertreat have raised concerns about quality and outcomes of care.

The main components of a QA program are

- 1) a QA entity;
- 2) a tool to measure/monitor quality;
- 3) a mechanism to correct problems;
- and
- 4) performance reports.

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*Perhaps the most important reason for conducting QA is to help consumers and purchasers make informed choices.*

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Generally, an internal entity conducts QA activities, but some plans contract with outside organizations to obtain QA services. The tool used to gauge quality can vary widely since “good quality care” is difficult to define. The National Committee for Quality Assurance (NCQA), which accredits QA programs, has developed the gold-standard set of health plan performance measures, called the *Health Plan Employer Data and Information Set*. These measures can be incorporated into outcomes, which is one way of determining whether or not a health plan’s practices are sound. If, for example, a health plan’s providers have different ways of managing a particular condition (e.g., surgery vs. pharmacologic therapy), the QA entity may examine which method results in the best outcomes for that health plan. Other tools include consumer

satisfaction surveys, morbidity/mortality data, tracking rates of iatrogenic incidents, and monitoring individual practice patterns.

Mechanisms for correcting deficiencies in quality usually entail taking the data collected and giving feedback to the providers individually or as a group. Feedback may take the form of practice guidelines or recertifying the plan’s providers. For example, a provider that has not met the plan’s standards of quality may be dropped from the plan (i.e., have their contract canceled).

Perhaps the most important reason for conducting QA, however, is to help consumers and purchasers make informed choices. Thus, performance reports are an important part of any QA program. Many managed-care organizations adapt the data from the QA tool for their performance reports. Some plans make their performance reports available to the public, but in general, more uniform and comprehensive sets of measures will need to be adopted so that the layperson will be better able to interpret the results. Performance reports also help the health plan keep track of quality from year to year.

## Utilization Review

Traditionally, physicians have had free reign over medical decision-making. With increasing pressure to control costs, physicians are finding their practice patterns questioned. Studies demonstrating that widely variable practice patterns may have little effect on outcomes have given insurance companies and other payers the opportunity to challenge health-care providers’ decisions. Utilization review (UR) is the mechanism by which insurance companies and managed-care organizations hold health-care providers accountable for costs. Basically, health-care payers hope to control costs by covering only “medically necessary” or “appropriate” care. Exactly what medical services are considered necessary or appropriate, however, will inevita-



bly vary among patients, physicians and payers. Thus, utilization review often becomes a bone of contention among all parties involved in the delivery of health care.

Different payers have different ways of performing UR. Essentially, the reviewer goes through all the health-care services and decides whether or not the payer will pay the provider for care. This can be done on a retrospective, concurrent or prospective basis. Under *retrospective review*, the service has already been provided to the patient. The reviewer then decides whether or not to reimburse the provider. *Prospective review* involves coverage decisions being made before the service is rendered—e.g., deciding whether or not hospitalization will be covered before the patient is admitted. *Concurrent review* takes place throughout the course of treatment (e.g., the patient's condition is monitored throughout hospitalization and coverage decisions are made on a day-by-day basis according to the patient's changing medical condition). Generally, the reviewers are trained health-care providers themselves (nurses, physicians, etc.) who analyze the appropriateness of medical decisions on a case-by-case basis. Reviewers often base coverage decisions on UR criteria. These criteria are practice guidelines which state the stipulations for coverage of a particular medical condition (e.g., a patient with medical condition X will be covered for the following procedures only if s/he meets criteria A, B or C). Any deviation from using the UR criteria will need to be justified by physician-reviewers or by the provider seeking reimbursement.

In addition to reviewing coverage decisions on a case-by-case basis, UR organizations are interested in keeping track of each provider's practice patterns. For example, the UR organization may generate a type of "utilization report card" for the health plan's physicians, where each physician's rates of utilization (e.g., number of MRIs ordered per year, number of days of hospitalization per patient, etc.) are compared

to the rates of the other physicians in the plan. If a physician consistently seems to order or perform a higher number of expensive procedures compared to her peers, she may find her contract with the managed care organization canceled.

The growth of UR activities has many ethical, legal and social implications. Patients have filed lawsuits for being harmed by an insurance company's refusal to cover particular services. For example, the plaintiff in *Wickline v. California* incurred complications leading to a leg

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***Utilization review is the mechanism by which insurance companies and managed-care organizations hold health-care providers accountable for costs.***

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amputation as a result of Medi-Cal's (California's Medicaid program) refusal to authorize an extra four days of hospitalization. Another set of lawsuits involve physicians who sue managed care organizations for canceling contracts based upon overutilization. Also, if physicians are constantly being judged according to their utilization of services, they may choose to care for only the healthiest of patients in order to improve their practice profiles. This, in addition to the inability of many sick patients to obtain adequate insurance coverage, creates a severe health-care access crisis. Finally, the ethical aspects of utilization review have not been examined. In light of physicians' duties to obtain informed consent, do patients have a right to know that their health care is being influenced by UR? That cost concerns may be coloring their provider's decisions? Do patients as consumers have a right to know what UR criteria their insurance company is using before they decide which plan to purchase? Many of the non-medical aspects of UR decisions have yet to be analyzed thoroughly. ♦

# Medicaid and Medicare

by Tammy Howard  
University of North Carolina at Chapel Hill, MD/PhD Program

**M**edicaid and Medicare are two large federal programs which provide medical insurance for elderly or indigent persons in the United States. Medicare and Medicaid are distinct, separate entities which serve, for the most part, different populations.

## Medicaid

According to 1994 census data, 12% of all Americans are insured by the Medicaid program. Medicaid was established in 1965 under Title XIX of the Social Security Act. This act permitted states, if they desired, to provide medical assistance to recipients of two welfare cash assistance programs: Aid to Families with Dependent Children (AFDC) and Aid to the Aged, Blind and Disabled. Participation in Medicaid by states is voluntary; states choose whether or

have a prescribed level of financial need in order to be eligible to receive Medicaid benefits. States which offer Medicaid also have the option of extending medical assistance to the *medically* indigent, defined as persons who are not sufficiently poor to qualify for cash assistance, but who cannot afford to pay for medical care.

Medicaid was designed so that it would be administered by states but jointly financed by state and federal funds. The federal government pays 50% to 83% of total Medicaid costs, the federal contribution being greater for states with lower per capita incomes. The federal legislation allowed each state to design and administer its own version of Medicaid. These gave the states a great deal of control in terms of deciding just how poor a person had to be in order to receive benefits. States could also decide how generous they would be in terms of the medical services extended to Medicaid recipients.

Although much of the public perceives Medicaid to be the insurance program for the poor, studies have indicated that 40% to 60% of the poor are ineligible for Medicaid. Having an income below the federal poverty standard is not enough to qualify for Medicaid. Low income and poor single adults, couples without children, and families with one working parent are usually not covered by standard Medicaid programs.

If adults do not qualify for Social Security insurance (SSI) by being blind, disabled or aged, they are sometimes left without any medical coverage at all. There have been numerous instances in which families with identical incomes living in the same state are not equally eligible to participate in Medicaid. This may seem puzzling, but the situation is explained by the way that federal and state laws are written to establish eligibility for AFDC and SSI. While a full analysis of these laws is beyond the scope of this essay, suffice it to say that it is possible for one poor family who receives SSI benefits to be eligible for Medicaid, while another family with an identical income and living in the same state are ruled ineligible for AFDC and therefore be ineligible for Medicaid.

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not to have a Medicaid program, and may discontinue their programs at any time. Unlike Medicare, Medicaid is not an entitlement program; it is a need-based program. Persons must

### Basic Benefits provided by Medicaid:

- Inpatient and outpatient hospital services
- Physician services
- Rural health clinic services
- Laboratory and x-ray services
- Skilled nursing facility services and home health services for those over 21
- The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) preventive health care and health maintenance program for children up to 21 years of age
- Family planning services

**Medicare**

According to 1994 census data, 13% of all Americans are insured by Medicare. Medicare is a medical assistance program for the elderly which was enacted by the federal government in 1965 under President Lyndon B. Johnson as title XVIII of the Social Security Act. Medicare provides health insurance coverage to all persons aged 65 and older (and their spouses aged 65 and over) who have paid into the Social Security system or Railroad retirement. Medicare is also extended to two categories of persons under age 65: those who suffer from end-stage renal disease, and disabled persons who have received Social Security disability benefits for at least 24 months. Medicare is not based on financial need; it is an entitlement program. Medicare pays a portion, but not all, of a recipient’s costs for medical care.

Medicare is funded from a number of sources, including payroll taxes, interest from Health Insurance Trust Funds and monthly premiums paid by recipients. Medicare consists of two parts: Part A, which provides insurance for hospital charges, and Part B, for physician services. Recipients must pay deductibles and co-insurance. For this reason, Medicare recipients often obtain additional medical insurance to cover these extra costs, known as “Medigap” insurance.

Medicare Part A is designed to help cover hospital charges incurred by eligible patients, meaning services received by Medicare recipients who have been admitted to a facility approved by Medicare. While Medicare Part A is more frequently associated with hospitals in the mind of the general public, it also helps pay for skilled nursing care in certain circumstances. Skilled nursing care refers to care provided under the direction of a physician or other licensed professional, such as a registered nurse, licensed practical nurse, speech pathologist or physical therapist. It includes treatments for inpatients who have illnesses or injuries that seriously affect life or health.

Medicare Part B covers outpatient treatments and physician services. The patient must pay an annual deductible, which was \$100 in 1991. After that, Medicare pays 80% of Medicare-approved charges. The patient must pay 20% of Medicare-approved charges, as well as any amount over the Medicare-approved charge if the treatment facility has not signed a contract with Medicare agreeing to always accept Medicare patients. Physicians who have not signed such a contract are said to accept Medicare assignment. Physicians who do not accept Medicare assignment may sometimes agree to

accept assignment on a case-by-case basis. As of 1991, physicians who do not accept Medicare assignment are allowed to charge Medicare patients up to 125% (or 140% in some cases) of the Medicare-approved amount, called the *maximum allowable actual charge*, for their services.

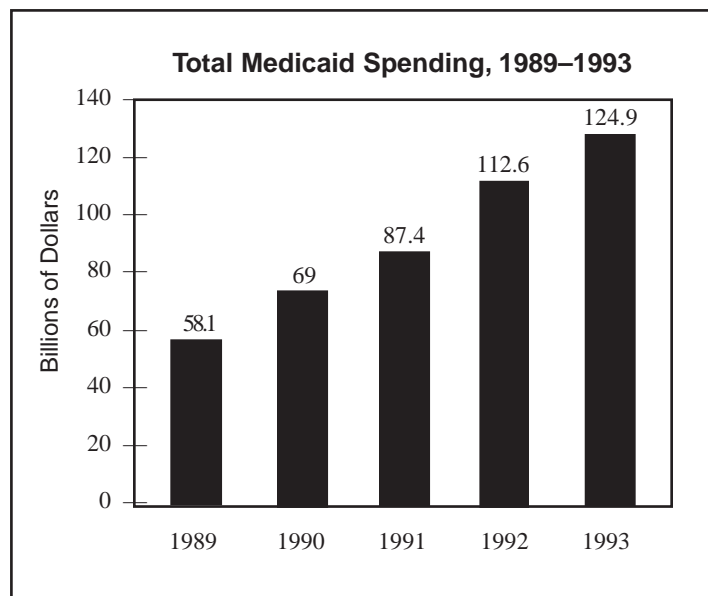
Medicare is the ultimate responsibility of the Department of Health and Human Services (DHHS). Within the DHHS, the Social Security Administration is responsible for handling Medicare eligibility and enrollment and the Health Care Financing Administration (HCFA) is responsible for defining rules, regulations and policies which govern Medicare (as well as Medicaid). ♦

**Services covered by Medicare Part A:**

- Hospitalization
- Skilled nursing facility
- Home health care
- Hospice care
- Nursing home care

**Services covered by Medicare Part B:**

- Medical expenses, including physician services, physical, occupational and speech therapy, medical equipment, diagnostic tests
  - Preventive care
- (Outpatient medications are not included).



Source: Kaiser Commission on the Future of Medicaid, 1994

# The Single-Payer Health-Care System

by Paul Jung  
University of Maryland School of Medicine

**T**he single-payer health-care system is a unique method of financing in which monies for health care are collected from citizens and businesses into a single public insurance fund administered by the government. This public fund finances the entire state or nation's health-care costs. Each citizen has free choice of providers and is fully covered for nec-

premium collection, advertisement and marketing. Canada's single-payer system spends only 0.9% on administration, while Medicare, the U.S. equivalent to a single-payer system, has an overhead of 2%. The U.S. General Accounting Office (GAO) estimates that savings from administrative streamlining under a single-payer plan would free up to \$83.2 billion to be used for direct patient care. This money could expand coverage to those currently without insurance or to those with inadequate coverage.

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Savings from a single-payer system may provide direct benefits to physicians. The House of Representatives commissioned a study of the Canadian health-care system which found that negotiated fee schedules in a single-payer system resulted in U.S. physicians spending 48% of their gross income on professional expenses, compared to only 36% for Canadian physicians, this resulting in savings "to be captured for the taxpayer."

essary health services without co-payments or deductibles. The fee-for-service private practices of physicians remain intact, and all physician and hospital bills are processed through the single public fund. A single-payer system would provide two benefits: minimized bureaucracy and universal coverage.

Under a single-payer proposal for the United States outlined in JAMA (see references, p.19), new taxes earmarked for health care would replace current insurance premiums collected from individuals, families and businesses. These earmarked taxes would amount to less than is currently paid for insurance premiums,

A criticism of single payer is that it rations care due to the constraints of a limited public fund. However, single-payer advocates point out that financial barriers are prevalent in the current U.S. system where rationing occurs based on one's ability to pay for services: 7% of Americans are denied care for financial reasons, whereas only 0.7% of Canadians are denied care for the same reason. As mentioned above, a U.S. single-payer system would be able to provide exactly the services currently provided to those Americans with coverage, but in addition would provide for those not covered by using administrative savings.

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***7% of Americans are denied care for financial reasons, whereas only 0.7% of Canadians are denied care for the same reason.***

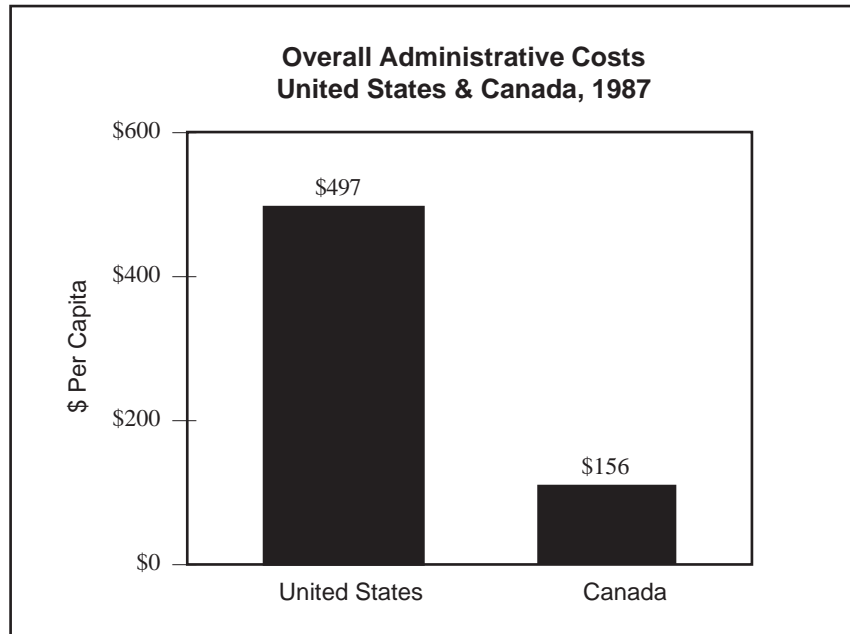
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Another criticism is that a not-for-profit single fund would slow the growth of medical innovation. However, there is no indication that a single-payer system will limit the technological advances available for medical care. Data actually show a higher use of high-tech medicine in single-payer systems. For example, Canadians have higher rates of heart and/or lung transplants, higher rates of liver transplants than their counterparts in the U.S., and comparable levels of kidney and bone marrow transplants.

yet due to decreased administrative costs the new system would have the same overall budget as the current U.S. system. Typical private insurance companies and HMOs spend between 12% and 25% of premiums on overhead. This overhead is used for billing, profits, risk evaluation,

There is evidence to suggest that a single-payer plan is popular among the American people. Polls show that 61% of Americans would prefer a single-payer system, while only 37% prefer the current U.S. system. However, single-payer advocates have been frustrated by political defeats—most recently in the 1994 California elections—and insurance industry counteradvertisement. However, single payer

has received recognition at the federal level. Most recently, a national single-payer bill (H.R. 1200) was introduced in the House by Congressman Jim McDermott, M.D. (D-WA) and numerous co-sponsors. There are also state single-payer initiatives pending in California again, Indiana, Massachusetts, Pennsylvania and New Jersey. ♦



Source: Woolhandler S, Himmelstein DU, "The Deteriorating Administrative Efficiency of the U.S. Health-Care System," *The New England Journal of Medicine*, 1991; 324: 1253-8.

# Future Health System Reform

by Rob Nordgren

Columbia University, College of Physicians and Surgeons and School of Public Health

**W**hen we speak of health-care “reform,” we must consider two arenas: the marketplace and public policy. Despite the demise of federal reform in 1994, our health-care system is changing rapidly. The current changes are being driven by managed

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*In the coming years, we will see more regulation of managed care at the state level.*

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care. As Lucia Lomotan points out in her article, there were 56 million Americans in HMOs at the end of 1995 and this number is expected to rise to 70 million by the year 2000. Managed care is altering the way we finance and deliver health care in the United States. Economic risk has been shifted to physicians who work under a capitated system and, as Andy Sikora states, managed care has created an atmosphere of downsizing and consolidation in our academic

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*While physicians have historically resisted government activism in the health-care system, they are now asking for strict regulation of a marketplace that is reducing their salaries and challenging their clinical autonomy.*

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health centers. In the years to come, the marketplace will put more emphasis on primary and preventive care, outcomes research and information systems. These changes will alter the curriculum of undergraduate and graduate medical education as academic institutions are forced to prepare their students for this brave new health-care world.

Public policy will play a reactionary role to the changes in the marketplace. In the coming years we will see more regulation of managed care at the state level. The legislation will

take an incremental approach to reform, much like the 48-hour maternal discharge laws enacted in several states or the new law in New Hampshire requiring HMOs to pay for nutritional formula for patients with Crohn’s disease. We will also witness medical societies battle managed care in state legislatures, as has already happened in states such as New York, Texas, Arkansas and many more. The issues will be anti-trust laws, “gag” rules imposed by managed-care companies and the hiring and firing practices of HMOs. While physicians have historically resisted government activism in the health-care system, they are now asking for strict regulation of a marketplace that is reducing their salaries and challenging their clinical autonomy.

At the federal level, it is unlikely that we will see the scope of activity that we witnessed around President’s Clinton’s *Health Security Act* again for several years. However, not everyone on Capitol Hill has forgotten about health-care reform. Senators Edward Kennedy (D- Mass.) and Nancy Kassebaum (R- Kan.) have ushered an insurance reform bill through the Labor and Human Resources Committee. This legislation would make it easier for workers to keep their health insurance when they change jobs or get sick, and it would bar insurers from denying coverage to people with diagnosed medical problems for more than 12 months if those workers previously had been covered by a group plan. In a rare display of bipartisan agreement, the measure passed the committee 16-0. Senator Robert Dole (R- Kan.) has reportedly expressed interest in bringing the bill to the Senate floor and he was urged to do so by President Clinton in the 1996 State of the Union address. However, the measure is being opposed by the insurance industry, a powerful lobby in Washington. Finally, if Congress and the White House agree on a welfare reform package, this federal legislation will have a significant effect on our health-care system by encouraging millions of Medicaid and Medicare recipients to join HMOs. ♦

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