Decoding the language of health-care financing: a primer

by Dimitri Drekonja, MD, MS, FACP

After what seemed like a short hiatus, health-care stories are creeping back into the news, with numerous (and often contradictory) claims: The Affordable Care Act (aka Obamacare) will stop small businesses from hiring. It is slowing the rise in health-care costs. It will destroy the American medical system. It is a huge gift to the insurance industry. It is socialized medicine. What to believe?

To start, it would help if more people could speak the arcane language of health-care financing. I recently was the attending physician at a local hospital. Since this piece is about translating the language of medicine into plain English, I should clarify that this means that medical students and residents (doctors-in-training) see and examine the patients first, then we talk about them, adjust plans as needed, and thus they learn the practice of medicine.

During these discussions, the topic of health-care financing recently came up, and I was surprised that the medical students had little understanding of how we pay for health care in the United States. They were well aware that we spend more than any other country, and that our outcomes are certainly not better because of this spending. But when asked about the differences between universal coverage, private insurance, Medicare, Medicaid, single-payer health care, socialized medicine, and Obamacare they quickly became confused.

This is not surprising — the topic is confusing, the terms often overlap, and they are frequently used incorrectly by public figures, including politicians and the media. However, it is unfortunate. We need the public to understand the language of health-care financing, since what path we ultimately choose has enormous implications for the physical and financial health of the U.S. population.

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To this end, it would be helpful if the public, and certainly medical professionals, understood the basic ways in which we finance health care, and examples of each one. So, here is a primer. People more versed in health policy than I am will likely find errors (hopefully small ones) or oversimplifications, but I hope this will be offset by the fact that more casual readers will understand the difference between socialized medicine and single-payer health care, and that universal coverage can be achieved in many different ways.

Universal coverage. This is not a type of financing. Rather, it is a description, and most people agree, a goal. It means that everyone has some sort of insurance coverage to pay for health care. It can be achieved via private insurance, public insurance, charity, or some combination. People disagree about just how far the U.S. is from universal coverage, but only the most dishonest of observers would say that we have it with our current system.

Private health insurance. This comes in many flavors, and indeed is provided by many (hundreds) of companies. Some are for-profit. Our hometown UnitedHealth Group is one. Minnesota does not allow for-profit insurers to sell plans in Minnesota, so I'll skimp on details. Suffice it to say that the name is descriptive, and reflects the fact that the primary focus of such insurers is to make money. This introduces an inherent conflict of interest (if care is denied, profits rise), and this is largely why Minnesota does not allow for-profit insurers to sell their products here.

The private health insurers we do have selling their plans in Minnesota include Blue Cross Blue Shield, HealthPartners, and many others. As nonprofits, they are supposed to return excess revenues to their policy-holders, or to invest such revenues in providing better care.

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These nonprofit private insurers negotiate different reimbursement rates both with care providers (local hospitals, clinics, nursing homes, etc) and with customers (large businesses, small businesses, and individuals). This negotiation (on both ends) is why comparison shopping between plans is difficult, and entails reading multiple 90-100 page PDF's describing each plan. If the company you work for is large and has good negotiators, you likely have a cheaper plan than the small business with 75 employees, let alone than an individual.

Public health insurance. Public insurance also comes in two main flavors: Medicare and Medicaid. Both are ways to pay for coverage — they are not government-run health care, they are government-run insurance plans that pay for health care. That care is delivered in the same facilities where people with private insurance go — next time you are in a clinic waiting room, you are likely sitting among patients with both private and public insurance. The care they get is the same. It is simply how the payment is handled that differs. Because Medicare and Medicaid cover many people, and because the government can negotiate rather well, the rates they pay are almost invariably cheaper than the rates private insurers pay.

Medicare is available to all those 65 and older (plus some others, including those with end-stage kidney disease), without restrictions based on pre-existing conditions, ability to pay, etc. In overly simple terms, Medicare part A covers hospital costs, Medicare part B covers outpatient costs, Medicare part C (Medicare+choice) is an option allowing beneficiaries to instead opt for plans provided by private insurers, and Medicare part D is a prescription drug benefit. Parts C and D were added later; thus, Medicare A and B are sometimes called "traditional Medicare." A little-known feature of Medicare is that it also funds the majority of graduate medical education in the U.S. — i.e., the salary of the physicians-in-training.

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The other main public health-insurance plan, Medicaid, is aimed at those with low-incomes, the disabled, and their children. Whereas Medicare is funded through federal payroll taxes, Medicaid is funded by a combination of federal and state dollars. Those people who have low incomes and are over 65 are "dual-eligible," meaning they can receive benefits from both programs. Since those on Medicaid are by definition without a lot of financial resources, copayments and out-of-pocket expenses are generally smaller than those seen with Medicare, or private insurance plans.

Single-payer health care. This is something that does not exist in the U.S. For full disclosure, I think it should be, and I belong to Physicians for a National Health Program, a group that advocates for a single-payer approach. The closest example is to the north (Canada), but many others exist around the world. Under a single-payer plan, instead of negotiating with and billing several hundred nonprofit and for-profit private insurers, hospitals and doctors bill a single government-run organization, just as they do now with Medicare. The funds come from a population-based tax, again, just as with Medicare. Given the similarities, some have referred to single-payer care as "Medicare for all."

Socialized medicine. Socialized medicine, which can occasionally be the "S word" of health-care reform, actually does exist in the U.S. In contrast to single-payer health care, where many different hospitals and providers provide care but send the bills to a single insurer, socialized medicine is government-run-and-owned health care. The U.S. example is the Veterans Affairs Administration (again, full disclosure, I am a physician at the Minneapolis VA). This means that the buildings and equipment are owned by the government, and the providers are government employees. In addition to providing health care, the VA also administers disability payments, something that needs to be taken into account when looking at what the VA spends for medical care. The British National Healthcare System is another example of socialized medicine, among many others.

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Finally, **Obamacare.** What is it? Grossly oversimplified, it is a plan to move toward universal coverage, primarily through an expansion of private health insurance. It expands private health insurance by several means, including: allowing young people to stay on their parents' plans for a longer time, eliminating the ability of insurers to exclude patients with pre-existing conditions, subsidizing the cost of private insurance for those making too much for Medicaid (but not enough to afford private insurance on their own), and creating insurance exchanges that are supposed to allow for easier comparing of plans. As written, it will not reach universal coverage, and the financial implications are uncertain.

Which system will ultimately help us reach the obvious goal of universal coverage? Who knows. The current system leads to the U.S. spending twice the money of any other country, for inferior results. Obamacare will improve access to health insurance, but will not lead to universal coverage without significant changes. If costs are not decreased, it seems unavoidable that something else will have to be tried, since the alternative would be unaffordable. In my opinion, a single-payer system is the logical next thing to try. If we do, we may want to remember the words of Winston Churchill: "We can always count on the Americans to do the right thing, after they have exhausted all the other possibilities."

Dimitri Drekonja, MD, MS, FACP, is a staff physician, Minneapolis VA Health Care System, and an assistant professor of medicine, University of Minnesota. The views expressed are his own, and not necessarily representative of the VA, the University of Minnesota, or Physicians for a National Health Program

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