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HEALTH CARE IN AMERICA: HOW TO FIX COSTS AND EMPLOYER PROVIDED INSURANCE THROUGH CONSUMER DRIVEN HEALTH CARE

A Capstone Experience/Thesis Project

Presented in Partial Fulfillment of the Requirements for

the Degree Bachelor of Arts with

Honors College Graduate Distinction at Western Kentucky University

By

Jonathan Williams

*****

Western Kentucky University
2011

CE/T Committee:

Professor Scott Lasley, Advisor

Professor Jeffrey Kash

Professor Craig T. Cobane

Approved by

_____

Advisor
Department of Political Science

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Jonathan Williams

2011

ABSTRACT

Consumer driven health care is a viable solution to reduce America's high overall health care costs and to rectify the lack of portability in the current employer driven health insurance model. Health care costs have risen greatly due to factors such as hospital administration and care, medical equipment, pharmaceutical companies, age, malpractice suits, and red tape. Health insurance is a complex field with components such as premiums, deductibles, co-payments, and both public and private providers of insurance. Health insurance in the United States is mainly provided by private insurance companies and these companies allow employers to pick insurance plans for their employees with the employee having little or no say on what is covered by these plans. Also, many employer based insurance plans are not able to travel from one company to another. Consumer driven health care can fix those issues. First, consumer driven health care is a system in which the individual controls their own health care choices and consumer health care is paid for by the individual instead of the government or employers. Consumer driven health care is also portable as health insurance plans are tied to the individual and not to a single company.

Keywords: Health Care, Consumer-Driven, Health Insurance, Portability, Employer Based, CDHP

Dedicated to my friends and family

ACKNOWLEDGEMENTS

I started this journey knowing very little of the complexities of health care. Since then, I have learned about HRA's, PPO's, and how to find the right information on the Department of Health and Human Services website. Thank you to the members of my committee and the Honors College staff. I would like to thank Dr. Scott Lasley for allowing and backing my study of health care as my first reader. The insight you provided helped to give me a focus to my work. I would like to give my thanks to Dr. Jeffrey Kash. Thank you as well to Dr. Craig T. Cobane for his support of my thesis.

I would have never found an interest in health care except for the guidance of Mr. Bob Shupe. You allowed me to journey into the world of insurance that fateful shadow day my senior year of high school. You allowed me the opportunity to see how employers negotiate with health insurance companies.

I would like to thank the Honors College for providing me a chance to grow and for the opportunity to write this thesis. I would like to thank Allie Kerns for her encouragement and unwavering support throughout this writing process. Finally, a big thank you goes to my family and friends for being their when I needed support.

VITA

February 26, 1989…… Born - Nashville, Tennessee

2007…….. Brentwood High School,
Brentwood, Tennessee

FIELDS OF STUDY

Major Field: Political Science

Minor Field: History

INTENTIONS

I will be attending Belmont Law School in the fall of 2011.

AWARDS

None

STUDY ABROAD

None

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CHAPTER 1

INTRODUCTION

Health care is one of the largest industries in the United States according to the Bureau of Labor Statistics.[1] The BLS found that over 14.3 million people were employed in health care related jobs in 2008.[2] Even though individual controlled health insurance plans and a free market health care are against the normal health insurance structure, individuals should control their own health insurance as it helps lower the massive amount of health care costs and creates a more portable market than employer based health plans allow. To understand why consumer driven health care is an available cure for the faults of health care one must look at how the current system works. One feature of the current health care system is high total costs. The high cost derives from areas such as administration (hospitals and medical organizations), drug companies, malpractice suits, business and governmental red tape, age, and medical equipment costs. The high cost of health care has pushed people to look at lowering health care costs. One method to lower health costs will be through a free market health care economy that is based around individual controlled health care. Health insurance is also an important part of American health care.

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[1] Bureau of Labor Statistics, "Health Care," United States Department of Labor, http://www.bls.gov/oco/cg/cgs035.htm (accessed April 21st, 2011).
[2] Bureau of Labor Statistics, "Health Care," United States Department of Labor, http://www.bls.gov/oco/cg/cgs035.htm (accessed June 16th, 2011).

Therefore, it is imperative to understand how health insurance works and who the main providers are. The current setup for health insurance is that it is controlled mainly through employers. This has led to issues such as low portability for a more mobile workforce and leads to higher costs. Individual controlled health insurance offers a potential remedy for the individual would take their insurance from employer to employer and not be limited by employer offerings. How can consumer-driven health care lower health care costs and reform the employer based insurance model?

SUMMARY

The research gathered for this project focuses on how the health care system should move towards consumer driven control of health insurance and free market health care principles. This is because high health care costs and employer control of health insurance limit the movement of health care plans. The first chapter of the paper is on how and why health care costs have increased. The next section explores how health insurance currently works and how employer provided health care has limited portability. The final section is on individual health insurance and why it offers a possible solution to lower costs and how its portability is better than employer health insurance. Health care costs have increased significantly over the last 20 years. It is important to discover why health care costs are so high to find solutions to the problem. The current health cost in America is among the highest in the world. According to the Kaiser Family Foundation (KFF) "expenditures in the United States on health care surpassed $2.3 trillion in 2008, more than three times the $714 billion spent in 1990," and "in 2008, U.S. health care spending was about $7,681 per resident and accounted for 16.2% of the nation's Gross

Domestic Product (GDP)."[3] So not only have health costs increased at a rapid rate but the high cost is spread to individuals and the nation as a whole. Figure 2.3 in chapter two provides a breakdown of national health care expenditures for 2008. The pie chart, shown in figure 2.3, breaks down health expenditures by using percentages for each major cost factor out of the total cost of health care. The KFF also lists several factors as to why health care costs have increased. This list includes hospital costs, medical technology, prescription drugs, chronic disease, hospital administration costs, and aging of the population. The Kaiser Foundation reports that "some analysts state that the availability of more expensive, state-of-the-art technological services and new drugs fuel health care spending not only because the development costs of these products must be recouped by industry but also because they generate consumer demand for more intense, costly services even if they are not necessarily cost-effective."[4] According to figure 2.3 from chapter two, the two largest factors that contribute to health care costs are hospital care and physician and clinical services. Hospital care and physician and clinical services combined "account for half (51%) of the nation's health expenditures."[5]

Pharmaceutical drugs are the third largest health care expenditure as they take up 10% of the total health care costs or around $230 billion dollars. The sections on pharmaceutical drugs discuss the path prescription drugs take from the manufacturer to

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[3] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed January 10, 2010).

[4] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed January 10, 2010).

[5] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed January 10, 2010).

the consumer and who the big players are in the pharmaceutical market and how that has increased costs for the consumer. Pharmaceutical companies and how they interact with the pharmaceutical market are well documented by a 2005 study by the Kaiser Family Foundation. The report follows the path prescription drugs take to reach the using customer. The study states that "pharmaceuticals originate in manufacturing sites; are transferred to wholesale distributors; stocked at retail, mail-order, and other types of pharmacies; subject to price negotiations and processed through quality and utilization management screens by pharmacy benefit management companies (PBMs); dispensed by pharmacies; and ultimately delivered to and taken by patients."[6] The synopsis of the pharmaceutical industry shows how complex the path is from development to the patient. The report goes into further detail on each of the stages of the path including the earnings of the largest American manufacturers and those of the wholesale distributors. IMS Health gives an annual report on the earnings of the top United States pharmaceutical manufacturing companies by sales while the *Pharmaceutical Executive* distributes a list of the top pharmaceutical companies by sales in the world.

America is aging and this increasing population of the elderly adds higher medical costs through areas such as increased medical care and nursing homes. The costs related to age are currently getting a boost from the baby boomers retiring and growing past the age of 65. The Center for Disease Control reported that the average life expectancy in

[6] The Henry J. Kaiser Family Foundation, "Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain," The Health Strategies Consultancy LLC, March 2005, http://www.kff.org/rxdrugs/upload/Follow-The-Pill-Understanding-the-U-S-Commercial-Pharmaceutical-Supply-Chain-Report.pdf (accessed January 12th, 2011), p.3

2007 was 77.9 years old.[7] One important option for reducing the cost for elderly healthcare is through technology. Indiana University pioneered a program known as GRACE to monitor elderly patients to reduce costs. The key component of the program is an "electronic medical record and tracking system."[8] This system helps keep track of things like diet and medicine intake to improve health. The final area studied under health care costs was red tape. One proposed method by the UnitedHealth Group to counteract red tape was to use electronic records. They specifically targeted the inefficiency of health care claims stating that "providers should be required to receive both claims payments and remittance advices electronically, eliminating millions of dollars in printing and postage costs and improving efficiency with bundled payments deposited directly into providers' bank accounts."[9]

The third chapter focuses on how health insurance works to highlight areas where consumer driven methods would alleviate the portability and limited choices under employer driven insurance. The chapter starts with a description from Discovery Health on health insurance as "paying a premium every month just in case something happens."[10] Health insurance coverage is then broken down into how it is paid for. Health insurance is paid for by co-payments and deductibles. Hereford Physical Therapy and

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[7] Center for Disease Control and Prevention, "Life Expectancy," cdc.gov, http://www.cdc.gov/nchs/fastats/lifexpec.htm (accessed October 1, 2010).
[8] Cindy Fox Aisen, "Aging with Grace: Health Care Delivery Model Yields Improved Outcomes and Lower Costs," EurekAlert, November 2, 2010, http://www.eurekalert.org/pub_releases/2010-11/iuso-awg110110.php (accessed January 15, 2011).
[9] UnitedHealth Group, "Health Care Cost Containment- How Technology Can Cut Red Tape and Simplify Health Care Administration," UnitedHealth Center for Health Reform and Modernization, June 2009, http://www.unitedhealthgroup.com/hrm/unh_workingpaper2.pdf (accessed November 16th, 2010), p.8.
[10] Lee Ann Obringer and Melissa Jeffries, "How Health Insurance Works," Discovery Health, February 04, 2006, http://health.howstuffworks.com/medicine/healthcare/insurance/health-insurance1.htm (accessed November 18th, 2010), p.2.

Sports Medicine defines co-payments as "a cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service."[11] Pat Ricks from Hereford Physical Therapy and Sports Medicine defines deductibles as "amounts required to be paid by the insured under a health insurance contract, before benefits become payable" and are "usually expressed in terms of an "annual" amount."[12]

The third chapter goes into research on how health insurance is provided. The research describes how health insurance is provided through both public and private methods. The federal and state governments are the main providers of public insurance. They provide this insurance through "Medicare, Medicaid, federal and state employee health plans, the military, and the Veterans Administration."[13] Private providers of health insurance are the other method of providing health insurance other than public. The two ways private insurance is provided is through "state-licensed health insuring organizations and self-funded employee health benefit plans."[14] There are multiple providers for state-licensed health insurance but there are three major ones. These three main providers include Blue Cross and Blue Shield, HMO's, and commercial insurance providers. The Blue Cross and Blue Shield Association (BCBSA) is the umbrella corporation that manages Blue Cross and Blue Shield plans. BCBSA has companies in every state and even in foreign countries. HMO's and other similar plans are provided by

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[11] Pat Ricks, "Co-Payment Versus Co-Insurance What's in Your Pocket?" Hereford Physical Therapy and Sports Medicine, http://www.herefordpt.com/copayment.shtml (accessed February 27th, 2011).
[12] Pat Ricks, "Co-Payment Versus Co-Insurance What's in Your Pocket?" Hereford Physical Therapy and Sports Medicine, http://www.herefordpt.com/copayment.shtml (accessed February 27th, 2011).
[13] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed March 12th, 2011).
[14] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed March 12th, 2011).

insurance companies. HMO's provide care as "they seek to reduce health care costs by identifying and treating illness early on, before it becomes a more serious--and costly—situation" and that "the HMO functions as a healthcare network" because "aside from emergencies, your Primary Care Physician (PCP) serves as your primary and initial point of contact for all health concerns."[15] There are two other group medical insurance plans similar to HMO's and they are called PPO's and POS's. PPO stands for Preferred Provider Organization and helps set fee schedules that medical facilities follow for individuals covered by a PPO. POS stands for Point Of Service plans and follows HMO policies except that POS's allow its users to seek medical help outside the coverage network. Employers are the largest providers of private insurance. The United States Census Bureau found that over 160 million Americans used employer based insurance in 2009.

METHODS

The method used for research on health care is derived from qualitative methods. A qualitative approach attempts "to understand a given research problem or topic from the perspectives of the local population it involves . . . qualitative research is especially effective in obtaining culturally specific information about the values, opinions,

[15] Health Insurance Info, "Health Maintenance Organizations (HMOs)," Health Insurance. Info: The Consumer's Health Insurance Authority, http://www.healthinsurance.info/guide/types/hmo (Accessed March 12th, 2011).

behaviors, and social contexts of particular populations."[16] Qualitative research then does not focus on the collection of new numerical data but in the understanding of data already available. It is through the focus of interpretation of data that qualitative research methods contrast themselves from quantitative methods. Robert Thomas writes that "quantitative methods . . . focus attention on measurements and amount . . . of the characteristics displayed by the people and events that the researcher studies" and that "quantitative research uses numbers and statistical methods . . . [and] seeks measurements and analyses that are easily replicable by other researchers."[17] Quantitative research is defined by strict rules and controlled variables so that others can repeat the same experiment. The goal is for everyone to reach similar results from the numbers. Qualitative research takes those numbers and tries to understand why those numbers came about and what those numbers mean. The information collected for this research paper was driven by government research and articles written by scholars about health care.

WHAT IS HEALTH CARE?

What is health care? Health care, in short, is the means to keep an individual healthy through doctors, nurses, hospitals, clinics, medical equipment, insurance companies, drug companies and any other companies and the people that work in medical

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[16] Family Health International, "Qualitative Research Methods: A Data Collector's Field Guide," FHI, http://www.fhi.org/nr/rdonlyres/etl7vogszehu5s4stpzb3tyqlpp7rojv4waq37elpbyei3tgmc4ty6dunbccfzxtaj2rvbaubzmz4f/overview1.pdf (accessed November 28th, 2010).

[17] Robert Murray Thomas, *Blending Qualitative and Quantitative Research Methods in Theses and Dissertations*, "Qualitative and Quantitative Defined," http://books.google.com/books?id=qx-yzSILfbMC&printsec=frontcover&dq=quantitative+research+methods&source=bl&ots=wfkQIVlGmH&sig=vn4kV4RiJnHynXA2IA_FITFvln0&hl=en&ei=28ryTM2lNoO0lQf2laD4DA&sa=X&oi=book_result&ct=result&resnum=2&ved=0CBwQ6AEwATgK#v=onepage&q&f=false (accessed November 28th, 2010), p.1-2.

fields. The health care definition listed above arose through my research on health care and the entities that work together within it. In essence, the health care system is how all those entities interact with each other. A few examples of how people interrelate with health care everyday is through annual checkups, flu shots at the local clinic, taking cough medicine when you are sick, and couch time with your friendly psychologist. A Rand Health report pinpoints three main health care issues. These issues are access, cost, and quality. The Institute of Medicine (IOM) defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[18] The IOM goes even farther and lists six goals to improve health care quality. These six goals of health care are that it should be "safe, effective, patient-centered, timely, efficient, and equitable."[19] Larry Nosse and Deborah Friberg echoed a similar sentiment on their definition of quality outcomes in their book *Management and Supervisory Principles for Physical Therapists*. They describe quality outcomes as "the belief that elimination of waste through increased efficiency and reduction in medical errors will reduce the cost of health care services while improving patient outcomes."[20] The next issue is access. Access is "a right or opportunity to reach or use or visit; admittance."[21] When applied to health care, access is the number of people who receive adequate health care in a suitable time period.

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[18] Institute of Medicine, "Crossing the Quality Chasm: The IOM Health Care Quality Initiative," Institute of Medicine of the National Academies, 2011, http://iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx (accessed April 20th, 2011).

[19] Institute of Medicine, 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academy Press, p.39-40.

[20] Larry J. Nosse and Deborah G. Friberg, 2010, *Management and Supervisory Principles for Physical Therapists*, "Overview of the Business of Health Care Delivery," 3rd ed., Philadelphia: Lippincott Williams and Wilkins, p.47.

[21] Frank R. Abate, 1997, *The Oxford Desk Dictionary and Thesaurus: American Edition*, "Access," *New* York, New York: Berkley Books, p.5.

A report by the Washington University medical colleges stated that "inadequate health insurance coverage is one of the major obstacles to healthcare access."[22] The individuals with health insurance are known as those with health care access. The individuals without access to health insurance are known as uninsured. Finally, cost is the third issue of health care. Cost is "a sum," or a "price."[23] Cost is an important issue of health care as total health care costs are in the trillions of dollars for the United States. All three of these health care problems were thrust more into the limelight by the 2010 Affordable Quality Health Care Act.

VIEW OF HEALTH CARE: AS A FREE MARKET

One of the ways that the health care system is viewed as is a free market enterprise that allows individual control of health insurance. Merriam-Webster defines a market economy as "an economic system in which prices are based on competition among private businesses and not controlled by a government."[24] A free market then is open trade between numerous entities with no single company or companies controlling trade through a monopoly. A monopoly is "complete control of the entire supply of goods or of a service in a certain area or market."[25] A free market system revolves around open interactions between consumers and companies. Grace-Marie Turner from the Heritage Foundation defines this consumerism as "more individual control over health care

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[22] Med Colleges of the University of Washington, "Professionalism Module," Colleges of the University of Washington School of Medicine, August 4th, 2009, http://medcolleges.washington.edu/icm2/sites/default/files/Access%20to%20Health%20Care.pdf (accessed June 10th, 2011).

[23] Frank R. Abate, 1997, *The Oxford Desk Dictionary and Thesaurus: American Edition*, "Cost," *New* York, New York: Berkley Books, p.164.

[24] Merriam-Webster, "Market Economy," Merriam-Webster's Learner's Dictionary, http://www.learnersdictionary.com/search/market%20economy (accessed March 13th, 2011).

[25] Merriam-Webster, "Monopoly," Merriam-Webster's Learner's Dictionary, http://www.learnersdictionary.com/search/monopoly (accessed March 13th, 2011).

decisions and health care spending" which gives "people more power and control over their health care and health insurance" which "creates new incentives for people to be more engaged in managing their health."[26] In other words, people that are given more control of their health care through the free market system will take better care of their health. Grace-Marie Turner's view of free market health care stems from the individual and not companies controlling health plans. She describes this plan as "a system that allows people to have health insurance that is portable; insurance that they can own and control; insurance that they, and not a politician or a human resources department, decide is right for them and their families."[27] Turner believes that the customer can decide better than other entities on what is the right insurance policy for their family. She describes that "for the past six years, the health sector has been moving toward more free-market solutions, introducing patient choice and competition into a system that had been largely dominated by top-down, centralized management."[28] Turner states that "our health sector is like a giant ship: It takes a great deal of effort to change direction, but even a small change can lead to a very different destination over time."[29] She uses this allegory of a ship to describe that health care is starting to steer in the right direction by allowing more individual control of health insurance. She uses these points to emphasize the continued control of insurance policies by employers with little to no individual preferences on

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[26] Turner, Grace-Marie, "Toward Free-Market Health Care," The Heritage Foundation, http://www.heritage.org/research/lecture/toward-free-market-health-care (accessed November 6th, 2010).
[27] Turner, Grace-Marie, "Toward Free-Market Health Care," The Heritage Foundation, http://www.heritage.org/research/lecture/toward-free-market-health-care (accessed November 6th, 2010).
[28] Turner, Grace-Marie, "Toward Free-Market Health Care," The Heritage Foundation, http://www.heritage.org/research/lecture/toward-free-market-health-care (accessed March 13th, 2011).
[29] Turner, Grace-Marie, "Toward Free-Market Health Care," The Heritage Foundation, http://www.heritage.org/research/lecture/toward-free-market-health-care (accessed July 6th, 2011).

insurance plans. Turner describes this connection of health insurance to employers as "our system of tying health insurance to the workplace is becoming antiquated with a workforce that is increasingly independent and mobile."[30] The next few chapters will show how increasingly high health care costs and employer controlled insurance plans has driven the need for greater individual control.

[30] Turner, Grace-Marie, "Toward Free-Market Health Care," The Heritage Foundation, http://www.heritage.org/research/lecture/toward-free-market-health-care (accessed April 10th, 2011).

CHAPTER 2

HEALTH CARE COSTS

The high cost of health care has given rise to an important question. How can the American public lower health care costs? One surprising answer is to have individuals manage their own health care needs. The focus would then shift to the consumer trying to mitigate cost. A person must first know where the cost of health care comes from before they can attempt to lower the costs.

HEALTH CARE COSTS IN GENERAL

Health care costs are high in America. But how high are health care costs currently? As of 2008, the overall health care system cost $2.3 trillion dollars in the United States. [31] The $2.3 trillion dollar cost does not seem large until converted into money per person rates. The per person rate is commonly known as the per capita value. The 2007 per capita health cost for the United States was $7,290 dollars while the next country in per capita rate, Norway, spent only $4,763 dollars per capita.[32]

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[31] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed May 24, 2010)

[32] The Commonwealth Fund, "International Profile of Health Care Systems" commonwealthfund.org, June 2010, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf (accessed June 26, 2010), p. 6.

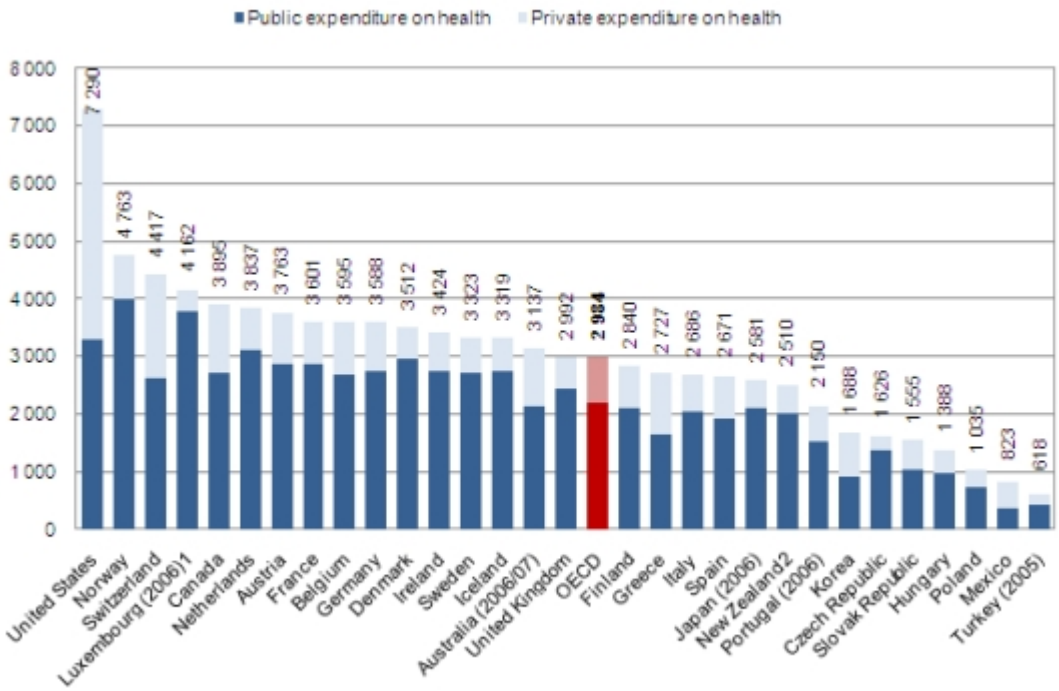

Figure 2.1. Total Health Expenditure per Capita, Public and Private, 2007. Source: Centre for Ageing Research and Development Ireland, *Expensive Health Care is not Always the Best Health Care, Says OECD's Health at a Glance* (OECD, December 8th 2009).

America spends more per capita on health care than any country in the world. What is more startling, though, is how fast the money spent on medical costs increased in the United States. The cost of health care in 1990 was only $784 billion dollars or about three

times less than the current cost.[33] This means that, since 1990, the health care costs were able to add $784 billion dollars about every seven years to its 1990 total. If the trend continues, we will easily see health expenditures over three trillion dollars within the next decade.

HEALTH CARE AS A PORTION OF THE GDP

Medical costs cover a large percentage of the overall economy of America. In fact, the Council on Foreign Relations estimates that health care covers around 17% of the United States GDP.[34] GDP is the average gross domestic product a country produces in a year. Essentially, the GDP is the overall economic output a country produces in a given year and this measure is often used to rate a country's wealth. For the United States, the GDP measures in the trillions of dollars. The first quarter of 2011 GDP for the United States was reported as just over $15.010 trillion dollars.[35] For comparison, the next closest country to America in the proportion of GDP used for health care is France with 11% of its GDP going toward health care in 2007.[36] The GDP of France for 2010 was $2.58 trillion dollars.[37]

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[33] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed May 24, 2010).

[34] Toni Johnson, "Healthcare Costs and U.S. Competitiveness," Council on Foreign Relations, March 23, 2010, http://www.cfr.org/health-science-and-technology/healthcare-costs-us-competitiveness/p13325 (accessed May 21, 2010).

[35] Bureau of Economic Analysis, "National Income and Product Accounts Table," Bureau of Economic Analysis U.S. Department of Commerce, May 26th, 2011, http://www.bea.gov/national/nipaweb/TableView.asp?SelectedTable=43&FirstYear=2010&LastYear=2011&Freq=Qtr (accessed June 13th, 2011).

[36] The Commonwealth Fund, "International Profile of Health Care Systems" commonwealthfund.org, June 2010, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf (accessed June 26, 2010), p. 6.

[37] U.S. Department of State, "Background Note: France," U.S. Department of State Diplomacy in Action, May 27th, 2011, http://www.state.gov/r/pa/ei/bgn/3842.htm (accessed June 13th, 2011).

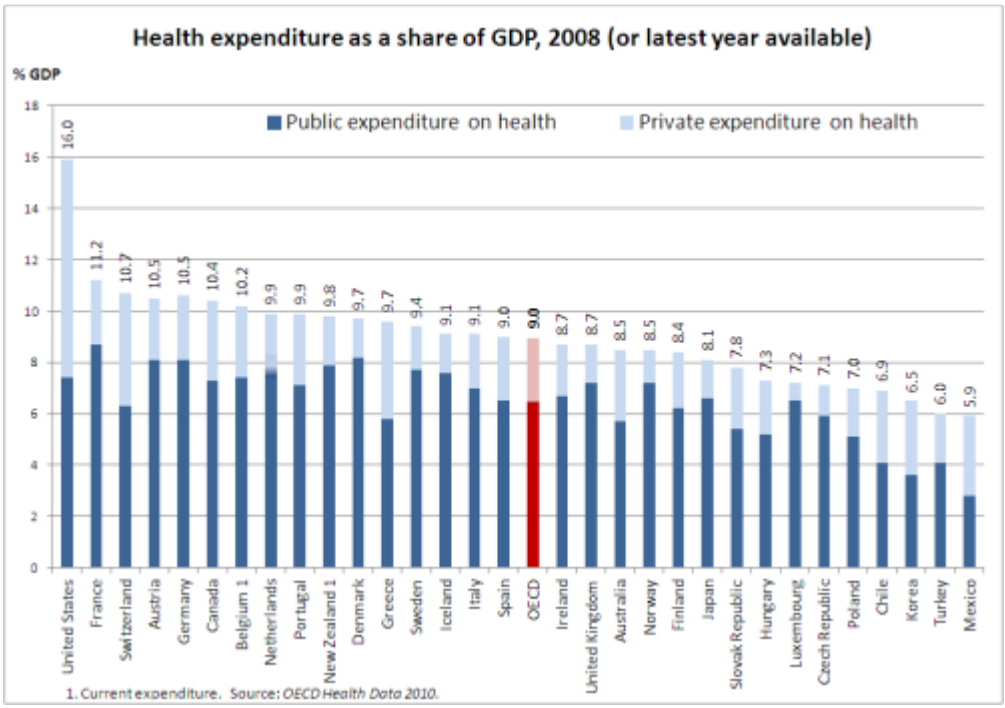

Figure 2.2. Health Expenditure as a Share of GDP, 2008. Source: OECD, *Growing Health Spending Puts Pressure on Government Budgets, according to OECD Health Data 2010* (OECD, June 6th 2010).

Back in 1990, health care was taking up 9.6% of the U.S. GDP.[38] Of note, the 1990 United States health care to GDP ratio was only 1.4% less than France's 2007 health care to GDP ratio. Health care, as a portion of the GDP, has risen dramatically since 1990. The current portion of the GDP taken up by health expenditures is 17% which means the portion taken up by health expenditures nearly doubled in 20 years. If current trends continue, the rate will increase to be over 20% of the GDP in the next 10 years.

[38] John B. Taylor, 2007, *Principles of Macroeconomics*, 5th ed., Boston, MA: Houghton Mifflin Company, p.25.

WHY HEALTH CARE COSTS INCREASED

There are several factors identified that have led to health care cost increases. The first and largest area of cost is the increase of physician and hospital care. Physician and hospital care combined to be over 52% of the total health care costs.[39] This is due to higher costs of hospital stays and for surgeries. Research and technological advances in medical equipment also increased costs. The overall administrative work in health care has grown causing higher expenses. The price of research and development of pharmaceutical drugs has risen sharply. The aging of America has added expenditures to health care. Nursing homes was one of the contributing factors that increases health care costs due to age. Governmental red tape and overlapping regulations have also led to increased costs due to redundancy. The next few sections will discuss at length on these topics.

[39] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed April 10th, 2011).

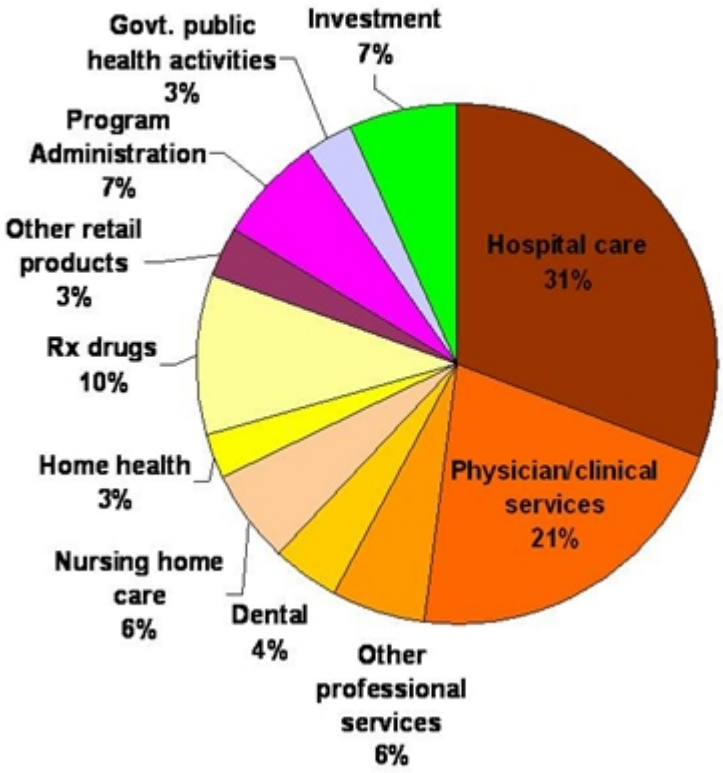

Figure 2.3. National Health Expenditures, 2008. Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *U.S. Health Care Costs* (Kaiser Family Foundation, March 2010).

HOSPITAL CARE

Hospital care makes up the largest single portion of health care costs. The hospital care costs alone account for 31% of the overall health care costs.[40] Hospital expenditures were in excess of $759 billion in 2009 which was up substantially over the 2001

[40] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed October 1st, 2010).

expenditure total of $449 billion.[41] Organizations such as the Agency for Health Care Research and Quality and the Health Care Cost and Utilization Project focus on hospitalization costs which are the costs of staying at a hospital. The overall hospitalization care costs in 2007 were $344 billion.[42] The hospitalization costs have increased though as the Healthcare Cost and Utilization Project found the 2008 hospitalization cost to be over $364 billion.[43] Hospital expenditures are from patient stays. Stays are visits to the hospital in which the patient spends any amount of time checked in. A stay can last a few hours to long term care that lasts for years. The majority of those that have a hospital stay are there for a procedure. Procedures are commonly called surgeries. In turn, procedures account for most of the hospital costs. Procedure costs were $296 billion dollars of the total hospital expenditures.[44] This is driven largely by individual cost increases for different types of surgery and care.

MEDICAL EQUIPMENT COSTS

Medical equipment costs are a portion of overall hospital costs. Medical equipment is the equipment is used for surgeries, normal checkups, and everyday medical needs. Medical equipment is placed into two categories. These categories are durable and nondurable equipment. Durable medical equipment is made to be used for multiple uses

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[41] Margaret E. Guerin-Calvert and Guillermo Israilevich, "Assessment of Cost Trends and Price Differences for U.S. Hospitals," American Hospital Association, March 2011, http://www.aha.org/aha/resource-center/Statistics-and-Studies/studies.html (accessed June 13th, 2011), p.9.

[42] Elizabeth Stranges, Allison Russo, and Bernard Friedman, "Procedures with the Most Rapidly Increasing Hospital Costs, 2004-2007," Health Care Cost and Utilization Project, http://www.hcup-us.ahrq.gov/reports/statbriefs/sb82.pdf (accessed October 22nd, 2010), p.1-2.

[43] HCUP, "HCUP Facts and Figures 2008-Section 1," Health Care Cost and Utilization Project, October 7th, 2010, http://www.hcup-us.ahrq.gov/reports/factsandfigures/2008/section1_TOC.jsp (accessed June 13th, 2011).

[44] Elizabeth Stranges, Allison Russo, and Bernard Friedman, "Procedures with the Most Rapidly Increasing Hospital Costs, 2004-2007," Health Care Cost and Utilization Project, http://www.hcup-us.ahrq.gov/reports/statbriefs/sb82.pdf (accessed October 22nd, 2010), p.1-2.

while nondurable medical equipment is used once. The American Hospital Association reported that durable medical equipment costs for the United States in 2009 was $34 billion while nondurable medical equipment costs for the same year was $43 billion.[45] The most expensive pieces of medical equipment are imaging machines. The common types of imaging machines used are x-rays, cat scans and magnetic resonance imaging machines. The Pennsylvania Health Care Cost Containment Council reports that "these technologies enable physicians to diagnose diseases at earlier stages while avoiding more invasive and costly diagnostic procedures."[46] Magnetic resonance imaging machines are commonly known as MRIs and are known to be very expensive. In fact, the initial cost of buying an MRI machine is two million dollars and has an upkeep of more than $800,000 a year.[47] The use of imaging procedures does come with the risk of overuse and overexposure to harmful radiation. The National Imaging Associates found that "multiple independent studies have concluded that as many as one-third of all advanced imaging services are either clinically inappropriate or they do not contribute to a physician's diagnosis or the ultimate health outcomes for the patient" and that "this overuse of imaging services poses a risk to patient safety, exposing people to potentially cancer-causing radiation unnecessarily."[48]

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[45] Margaret E. Guerin-Calvert and Guillermo Israilevich, "Assessment of Cost Trends and Price Differences for U.S. Hospitals," American Hospital Association, March 2011, http://www.aha.org/aha/resource-center/Statistics-and-Studies/studies.html (accessed April 16th, 2011), p.8.
[46] Pennsylvania Health Care, "The Growth in Diagnostic Imaging Utilization," Pennsylvania Health Care Cost Containment Council, http://www.phc4.org/reports/fyi/fyi27.htm (accessed June 13th, 2011).
[47] Pennsylvania Health Care, "The Growth in Diagnostic Imaging Utilization," Pennsylvania Health Care Cost Containment Council, http://www.phc4.org/reports/fyi/fyi27.htm (accessed November 12th, 2010).
[48] NIA, "America's Imaging Challenge," National Imaging Associates A Magellan Health Company, 2011, http://www.niahealthcare.com/industry-trends/america%27s-imaging-challenge.aspx (accessed June 13th, 2011).

HOSPITAL ADMINISTRATION COSTS

Hospital administration is the means to keep a hospital running effectively and efficiently. This includes paper work, setting schedules, planning for use of beds, and the ordering of important supplies. The U.S. Department of Labor states that hospital administrators "plan, direct, coordinate, and supervise the delivery of health care."[49] Some administrators even train doctors and nurses on hospital protocol and hire those individuals as well. A hospital would not be able to run without proper administration. The hospital administration cost for the year 1999 was $89.9 billion dollars.[50]

PHARMACEUTICAL DRUGS: THE PATH TO MARKET

Pharmaceutical drugs, or better known as prescription drugs, are a significant contributor to health care costs. The Kaiser foundation reports that around 10% of the overall medical costs come from prescription drugs.[51] A large portion of pharmaceutical drug costs stem from the long process a drug must progress through to sell on the market. The Kaiser Family Foundation published a 2005 report that detailed the long and arduous path a new drug must take to make it on the market. The process starts when pharmaceutical companies, also referred to as manufacturers, research a new type of drug. For the United States, the top five manufacturers are Pfizer, Merck and Co.,

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[49] U.S. Bureau of Labor Statistics, "Medical and Health Services Managers," United States Department of Labor, December 17th, 2009, http://www.bls.gov/oco/ocos014.htm (accessed November 6th, 2010).
[50] Woolhandler, Steffie, Terry Campbell, David Himmelstein, "Costs of Health Care Administration in the United States and Canada," The New England Journal of Medicine, August 21, 2003, http://www.nejm.org/doi/full/10.1056/NEJMsa022033 (accessed October 22, 2010).
[51] The Henry J. Kaiser Family Foundation, "Trends in Health Care Costs and Spending" Health Care Marketplace Project, March 19th, 2009, http://www.kff.org/insurance/7692.cfm (accessed June 25, 2010), p.1.

AstraZeneca Corp., GlaxoSmithKline, and Roche.[52] These companies play the largest single role in the process of getting a drug to market. In fact, wholesale distributors, pharmacies, and pharmacy distributor managers all deal directly with the pharmaceutical manufacturers on areas such as cost and distribution to consumers.[53] The system is built with the manufacturers at the top. They are the group that creates, tests, and initially develops drugs. The prescription drug corporations are further split into brand name and generic manufacturers. A Health Strategies Consultancy LLC research report defines brand companies as those that do the development of a new drug while generic companies make generic versions of the brand companies' product.[54] The prescription drugs are then sold to wholesale distributors. The top three distributors are McKesson Corp., Cardinal Health Inc., and AmerisourceBergen Corp. [55] The wholesale distributors' then sell the prescription drugs to different medical entities. The largest medical entity to receive prescription drugs are the pharmacies. Pharmacies range from small mom and pop types to large chains such as Walgreens, CVS, and Wal-Mart. The pharmacies sell both brand and generic made medicine to the consumer. Figure 2.4 gives a visual of the myriad interactions of these factors in getting pharmaceutical drugs to the consumer.

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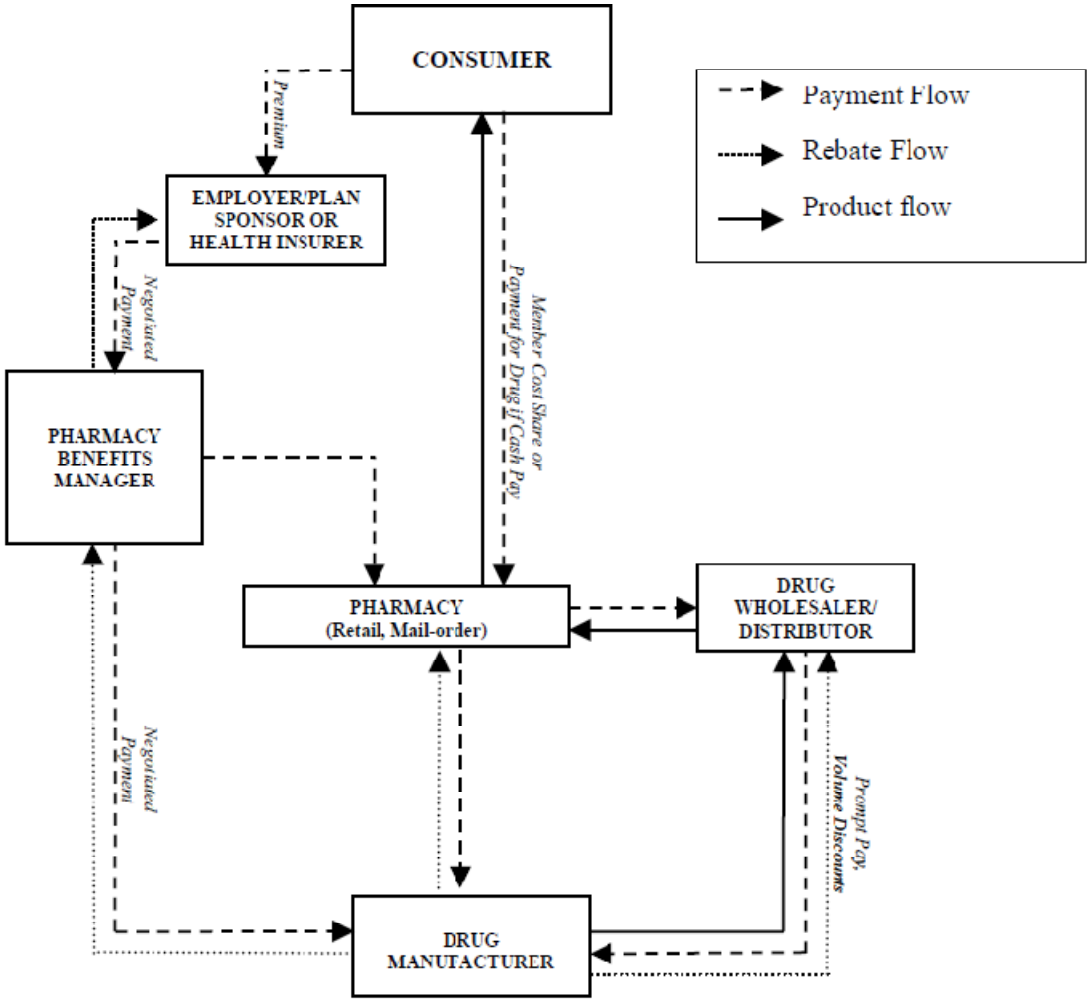
[52] IMS Health Incorporated, "2009 U.S. Sales and Prescription Information: Top 15 Companies by U.S. Sales," IMS, http://www.imshealth.com/deployedfiles/imshealth/Global/Content/StaticFile/Top_Line_Data/Top%20Corps%20by%20U.S.Sales.pdf p.1 (accessed November 10, 2010).

[53] The Henry J. Kaiser Family Foundation, "Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain," The Health Strategies Consultancy LLC, March 2005, http://www.kff.org/rxdrugs/upload/Follow-The-Pill-Understanding-the-U-S-Commercial-Pharmaceutical-Supply-Chain-Report.pdf (accessed January 12th, 2011), p. 1-3.

[54] The Henry J. Kaiser Family Foundation, "Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain," The Health Strategies Consultancy LLC, March 2005, http://www.kff.org/rxdrugs/upload/Follow-The-Pill-Understanding-the-U-S-Commercial-Pharmaceutical-Supply-Chain-Report.pdf (accessed January 12th, 2011), p.4.

[55] Modern Distribution Management, "2010 MDM Market Leaders: Top 10 Pharmaceutical Wholesalers," MDM, May 27th, 2010, http://www.mdm.com/2010-mdm-market-leaders-top-10-pharmaceutical-wholesalers/PARAMS/article/26126 (accessed November 9th, 2010).

Exhibit 1. Flow of Goods and Financial Transactions Among Players in the U.S. Commercial Pharmaceutical Supply Chain



Source: The Health Strategies Consultancy LLC

Figure 2.4. Flow of Goods and Financial Transactions among Players in the U.S. Commercial Pharmaceutical Supply Chain. Source: The Health Strategy Consultancy LLC, *Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain* (Kaiser Family Foundation, March 2005).

Notice that there is no direct path to the consumer. They are last in the pharmaceutical chain and as such they receive the medicine last. The consumer normally receives their prescription drugs directly from a pharmacy.

PHARMACEUTICAL DRUGS: COST FACTOR

The cost factor from pharmaceutical drugs in the United States stems from the complex system to market and control by pharmaceutical manufacturers. The two factors lead to high costs of prescription drugs for the consumer. Many European countries, such as England, France, Germany, the Netherlands, Denmark, and Sweden, have caps on how much consumers can spend on prescriptions and "use reference pricing schemes to give patients financial incentives to select less-expensive medications when more than one choice exists."[56] Reference pricing is when "insurers cover only the low-cost, benchmark drugs in a therapeutic class and patients pay the difference in price if they want higher-cost alternatives."[57] Therefore, prescription drug costs are lower in Europe versus the United States do to reference pricing and caps on prescription costs. The United States did attempt the use of reference pricing through Medicare but groups such as "AARP, the

[56] Sarah Thomson and Elias Mossialos, "Primary Care and Prescription Drugs: Coverage, Cost-Sharing, and Financial Protection in Six European Countries," The Commonwealth Fund, March 2010, http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Mar/Primary-Care-and-Prescription-Drugs-Coverage-Cost-Sharing-and-Financial-Protection.aspx (accessed June 13th, 2011), p.5.
[57] Panos Kanavos and Uwe Reinhardt, "Reference Pricing for Drugs: Is It Compatible with U.S. Health Care?" The Commonwealth Fund, May 1st, 2003, http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2003/May/Reference-Pricing-for-Drugs--Is-It-Compatible-with-U-S--Health-Care.aspx (accessed June 13th, 2011).

advocacy group for older Americans, urged CMS," the Center for Medicare and Medicaid Services "to ban reference-based pricing," due to "reference-based pricing made it difficult for consumers to calculate drug costs."[58] It does not end there. One of the major concerns by U.S. pharmaceutical companies is that reference pricing will stifle prescription drug research but a study by Salomeh Keyhani found that "higher prescription drug spending in the United States does not disproportionately privilege domestic innovation, and many countries with drug price regulation were significant contributors to pharmaceutical innovation."[59] As discussed earlier, the path of prescription drugs flows through at least three entities before reaching the individuals on the medication. The direct result of this long path is increased costs. The top three manufacturers by sales in the United States each make over $17 billion dollars worth in sales.[60]

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[58] Jane Zhang and Vanessa Fuhrmans, "Medicare Seeks to Ban Some Penalties for Picking Brand-Name Drugs," *The Wall Street Journal*, January 10th, 2009, http://online.wsj.com/article/SB123155109820170249.html (accessed June 13th, 2011).

[59] Salomeh Keyhani, Steven Wang, Paul Hebert, Daniel Carpenter, and Gerard Anderson, "US Pharmaceutical Innovation in an International Context," *American Journal of Public Health*, June 2010, vol. 100, no. 6, http://ajph.aphapublications.org/cgi/content/abstract/100/6/1075 (June 13th, 2011), p.1075-1080.

[60] IMS Health Incorporated, "2009 U.S. Sales and Prescription Information: Top 15 Companies by U.S. Sales," IMS, http://www.imshealth.com/deployedfiles/imshealth/Global/Content/StaticFile/Top_Line_Data/Top%20Corps%20by%20U.S.Sales.pdf p.1 (accessed November 10, 2010).

Top Corporations by U.S. Sales
US$ in Billions

RANK		2009	2008	2007	2006	2005
	Total US Prescription Market	**300.3**	**285.7**	**280.5**	**270.3**	**247.3**
1	PFIZER	27.8	27.7	31.4	34.2	34.3
2	MERCK & CO	19.8	20.1	21.9	20.6	18.7
3	ASTRAZENECA CORP	18.3	16.1	15.2	14.5	12.4
4	GLAXOSMITHKLINE	15.0	16.5	18.3	18.7	17.0
5	ROCHE	14.3	12.6	11.9	10.2	8.0
6	NOVARTIS	13.4	12.2	13.5	13.6	12.6
7	LILLY	13.2	12.0	10.7	9.7	8.9
8	JOHNSON & JOHNSON	12.8	15.6	15.9	15.7	15.6
9	AMGEN CORPORATION	12.5	12.8	13.6	14.2	11.6
10	TEVA PHARM USA	12.1	11.2	9.8	9.0	7.3
11	SANOFI AVENTIS	11.1	10.7	10.6	10.7	10.9
12	ABBOTT	9.5	9.7	9.3	9.3	8.5
13	BRISTOL-MYERS SQUI	8.9	7.9	6.7	6.2	8.1
14	TAKEDA	7.9	7.9	7.6	7.0	6.4
15	BOEHRINGER INGEL	7.6	6.3	5.7	5.5	5.0

Copyright IMS HEALTH, a healthcare information company
Source: IMS National Sales Perspectives™

Report reflects Prescription-bound products including Insulins (and excludes other products such as OTC)

Figure 2.5. Top Corporations by U.S. Sales, 2005-2009. Source: IMS National Sales Perspectives, *2009 U.S. Sales and Prescription Information* (IMS Health Incorporated, April 6th 2010).

How do these companies rank against sales from other countries around the world? The top five manufacturers by United States sales of Pfizer, Merck and Co., AstraZeneca Corp. GlaxoSmithKline, and Roche all rank in the top eight sales worldwide.[61]

[61] Pharm Exec Staff, "The Pharm Exec 50," Pharmaceutical Executive, May 1st, 2009, http://pharmexec.findpharma.com/pharmexec/data/articlestandard//pharmexec/202009/597526/article.pdf (accessed November 16th, 2010).

Rank ['07 Rank]	Company & Headquarters [Web site]	2008 Global Pharma Sales [change from 2007]	R&D Spend	2008 Top-Selling Drugs [2008 sales]
1 [1]	Pfizer New York, NY [pfizer.com]	$44.2 B [-0.5%]	$7.9 B	Lipitor [$12.4 B] Lyrica [$2.6 B] Celebrex [$2.5 B]
2 [2]	GlaxoSmithKline Brentford, England [gsk.com]	$43.0 B [11.2%]	$5.2 B	Seretide/Advair [$6.0 B] Valtrex [$1.7 B] Lamictal [$1.4 B]
3 [3]	Sanofi-Aventis Paris, France [sanofi-aventis.com]	$38.7 B [4.8%]	$6.5 B	Lovenox [$3.9 B] Plavix [$3.7 B] Lantus [$3.5 B]
4 [4]	Novartis Basel, Switzerland [novartis.com]	$36.0 B [10.7%]	$7.2 B	Diovan/Co-Diovan [$5.7 B] Gleevec/Glivec [$3.7 B] Zometa [$1.4 B]
5 [5]	AstraZeneca London, England [astrazeneca.com]	$31.6 B [10.1%]	$5.1 B	Nexium [$5.2 B] Seroquel [$4.5 B] Crestor [$3.6 B]
6 [6]	Johnson & Johnson New Brunswick, NJ [jnj.com]	$24.6 B [-1.2%]	$5.1 B	Remicade [$3.7 B] Topamax [$2.7 B] Procrit [$2.5 B]
7 [7]	Merck Whitehouse Station, NJ [merck.com]	$23.6 B [-2.4%]	$4.8 B	Singulair [$4.4 B] Cozaar/Hyzaar [$3.6 B] Fosamax [$1.6 B]
8 [8]	Roche Basel, Switzerland [roche.com]	$21.0 B [3.4%]	$7.2 B	MabThera/Rituxan [$5.6 B] Avastin [$4.9 B] Herceptin [$4.8 B]
9 [10]	Eli Lilly Indianapolis, IN [lilly.com]	$19.3 B [9.6%]	$3.8 B	Zyprexa [$4.7 B] Cymbalta [$2.7 B] Gemzar [$1.6 B]
10 [9]	Wyeth Madison, NJ [wyeth.com]	$19.0 B [2.3%]	$3.4 B	Effexor [$3.9 B] Prevnar [$2.7 B] Enbrel [$2.6 B]

Figure 2.6. The Pharmaceutical Executive 50, 2008. Source: Pharm Exec 50, *The Pharm Exec 50: We Leap Tall Buildings to bring You the Definitive Guide to the World's Top Pharma Companies* (The Pharmaceutical Executive, May 2009).

The wholesale distributor companies of the McKesson Corp., Cardinal Health Inc., and AmerisourceBergen Corp make even more money than the manufacturers. These three companies combined make over $250 billion dollars.[62]

AGE

Age plays a large role in the cost of health care. The older you get the more an individual pays for health care. A 2005 study reported that individuals aged 64 and under

[62] Modern Distribution Management, "2010 MDM Market Leaders: Top 10 Pharmaceutical Wholesalers," MDM, May 27th, 2010, http://www.mdm.com/2010-mdm-market-leaders-top-10-pharmaceutical-wholesalers/PARAMS/article/26126 (accessed November 9th, 2010).

spent about $2,000 dollars for health care while individuals over 65 spent about $12,000 dollars on health care.[63]

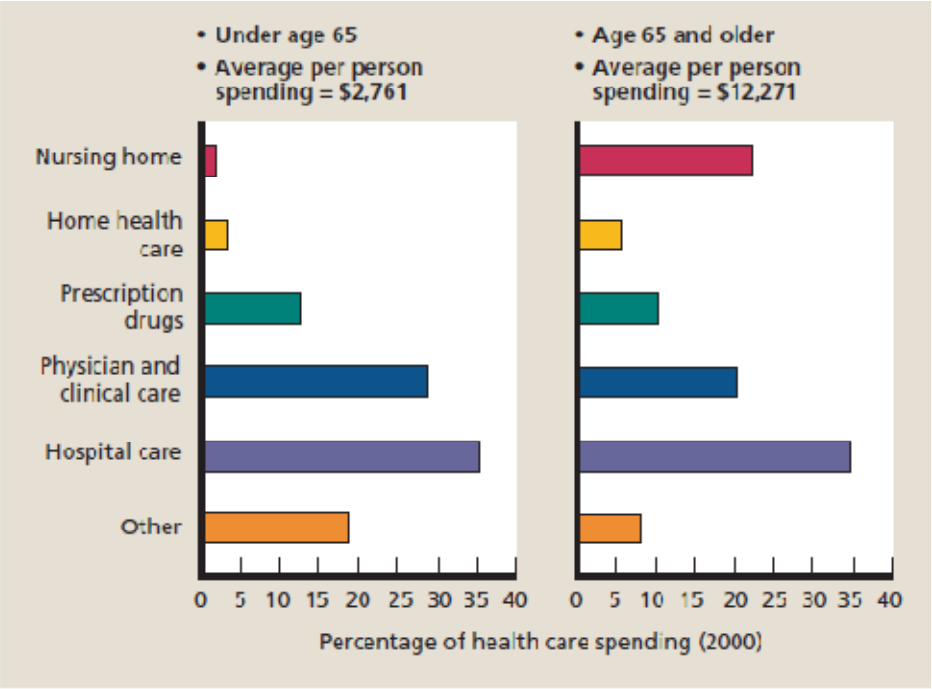

Figure 2.7. The Elderly Spend Much More on Health Care and the Services They Buy are Different, 2000. Source: Dana P. Goldman and Elizabeth A. McGlynn, *U.S. Health Care: Facts about Cost, Access, and Quality* (Rand Health Corporation, 2005).

A majority of this money goes towards checkups, Medicare, and nursing homes. Medicare is health insurance for the elderly. Medicare covers regular checkup and hospital stay fees. But what effect does aging have on the health care system? The largest factor aging has is increased costs to care for individuals as the elderly live longer. The

[63] Dana P. Goldman and Elizabeth A. McGlynn, "U.S. Health Care: Facts about Cost, Access and Quality," Rand Corporation, 2005, http://www.rand.org/pubs/corporate_pubs/CP484z1.html (accessed September 12, 2010), p.7.

life expectancy for the United States was 77.9 in 2007 and is expected to continue increasing.[64] The longer a person lives the more it costs to keep that person "healthy". Elderly persons take more medicine on average than younger individuals. The larger amount of medicines needed by the elderly means that they pay more for prescription drugs. Total costs are higher for those over 65 as they are more susceptible to illness. Since the elderly are more susceptible to illness, they visit physicians and hospitals often causing them to pay higher clinical fees. European countries take care of their elderly through several different methods. These methods include "making primary care free for everyone, with no copayments or other cost-sharing (Denmark, England, the Netherlands)," and "the most anyone pays out-of-pocket in a year for publicly financed primary care—including visits to office-based specialists but excluding prescription drugs—ranges from nothing in Denmark and England to $56 in Germany (if patients accept referral requirements for seeing specialists), $109 in Sweden, and $199 in the Netherlands," and "exemption for people age 60 and older (England)" on prescription drug costs.[65] Nursing homes are the major beneficiaries of the aging of America. It becomes harder for individuals to take care of themselves or for families to take care of individuals over the age of 65. A nursing home provides an answer. The elderly are given their own rooms but with nurses and other medical attention just down the hall. Nursing homes are an expensive venture. Nursing homes now account for over 6% of the total

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[64] Center for Disease Control and Prevention, "Life Expectancy," cdc.gov, http://www.cdc.gov/nchs/fastats/lifexpec.htm (accessed October 1, 2010).

[65] Sarah Thomson and Elias Mossialos, "Primary Care and Prescription Drugs: Coverage, Cost-Sharing, and Financial Protection in Six European Countries," The Commonwealth Fund, March 2010, http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Mar/Primary-Care-and-Prescription-Drugs-Coverage-Cost-Sharing-and-Financial-Protection.aspx (accessed June 13th, 2011), p.4-5.

health care costs. [66] The financial strain, on either the elderly individual or their family, for keeping a loved one in a nursing home can be overbearing. A 2002 study by Pacific Life Insurance found that nursing home costs averaged $61,000 dollars a year.[67] That cost is over what most Americans make in a year. The cost of nursing home stays has risen even higher though. A 2010 study by Northwestern Mutual found that nursing home costs averaged around $90,000 a year.[68] That is a $30,000 dollar increase of cost in only eight years. The $30,000 dollar increase in eight years equates to around $4,000 dollar cost increase every year. The American public can expect higher costs as more of the population ages and moves into nursing homes.

HOW TO DEAL WITH AGE COSTS

What can be done about age costs? There are two main methods that people use to pay for elderly care. These two methods are private funds and public financing from Medicare and Medicaid.[69] The first fix would stem from Medicare and Medicaid financing more for elderly care. They cover the largest portion of public programs to pay for old age health care. Medicare and Medicaid are already expensive programs though. The 2008 spending on Medicare was over $500 billion and the spending on Medicaid

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[66] The Henry J. Kaiser Family Foundation, "U.S. Health Care Costs," kaiseredu.org, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (accessed January 10, 2010).

[67] Pacific Life Insurance Company, "Nursing Home Costs," Pacific Life, April 2002, http://www.pacificlife.com/Channel/Educational+Information/Taxes+Glossary+and+Other/Nursing+Home+Costs.htm (accessed November 6th, 2010).

[68] Long Term Care Group, Inc., "Cost of Long Term Care Study: Nursing Homes," Northwestern Mutual Insurance, June 2010, http://www.northwesternmutual.com/learning-center/studies-and-reports/cost-of-long-term-care-study.aspx#Nursing-Homes (accessed November 6th, 2010).

[69] National Clearinghouse for Long Term-Care Information, "Public Programs that Pay for Long-Term Care," U.S. Department of Health and Human Services, May 12th, 2010, http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx (accessed November 6th, 2010).

during the same year was over $370 billion dollars.[70] Therefore, the increase of spending from Medicare and Medicaid to pay for long term care would be counterintuitive to lowering health care costs. Private funds would provide a more cost effective approach to old age care. Private funds are funds provided by the individual whether that is out of pocket, long term health insurance, or equities.[71] Equity is the monetary value of a property according to Merriam Webster.[72] Home equities are the borrowing against the property value of your house. This is a risky venture as home property values fluctuate and you can lose ownership of your home. An easier path would be to raise awareness and start private funds at an early age for later in life. Technology is another way to deal with old age health care costs. The costs are lowered through improvements in health care related technology. Primary care is one focus area that technology is applied to lower elderly age costs. Indiana University addressed this in a study known as GRACE. GRACE stands for Geriatric Resources for Assessment and Care of Elders.[73] GRACE is built around a system that involves a nurse practitioner and social worker visiting the elderly individuals' home and creates a profile of the person. This profile covers includes what medicines the person takes, if they exercise, and even what foods they normally eat.

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[70] Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2009-2019," U.S. Department of Health and Human Services, September 2010, http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf (accessed November 9th, 2010).

[71] National Clearinghouse for Long-Term Care Information, "Evaluating Your Options," U.S Department of Health and Human Services, October 22nd, 2008, http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Private_Programs/Private%20Financing/index.aspx (accessed November 6th, 2010).

[72] Merriam-Webster, "Equity," An Encyclopedia Britannica Company, http://www.merriam-webster.com/dictionary/equity (accessed November 6th, 2010).

[73] Cindy Fox Aisen, "Aging with Grace: Health Care Delivery Model Yields Improved Outcomes and Lower Costs," EurekAlert, November 2, 2010, http://www.eurekalert.org/pub_releases/2010-11/iuso-awg110110.php (accessed January 15, 2011).

Then, the GRACE workers input the data into "an electronic medical record and tracking system, the GRACE support team provides ongoing comprehensive care management."[74] The study found that GRACE "improved health and quality of life, decreased emergency department visits and lowered hospital admission rates in a group at high risk for hospital admission."[75] Thus, elderly patients were able to stay healthier and lowered overall medical costs by having less emergency visits.

MALPRACTICE SUITS

Malpractice suits are the smallest cost factor of health care. The importance lies in the fact that doctors must pay insurance companies to protect them and that case settlements can be expensive. Malpractice is the suing of a doctor for failure to perform up to acceptable standards or when a doctor causes harm to their patient through negligence. Doctors pay a yearly premium for their malpractice insurance. The premium cost is different from state to state and can have different levels depending on the county. This is due to the fact that "malpractice law has traditionally been under the purview of state governments, nearly every state has some type of policy in place that addresses medical liability."[76] The *Medical Liability Monitor* does a yearly rate study on the premium costs for all 50 states and the District of Columbia. Their study follows the premium rates for internal medicine, general surgeons and obstetrics/gynecology doctors.

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[74] Cindy Fox Aisen, "Aging with Grace: Health Care Delivery Model Yields Improved Outcomes and Lower Costs," EurekAlert, November 2, 2010, http://www.eurekalert.org/pub_releases/2010-11/iuso-awg110110.php (accessed January 15, 2011).
[75] Cindy Fox Aisen, "Aging with Grace: Health Care Delivery Model Yields Improved Outcomes and Lower Costs," EurekAlert, November 2, 2010, http://www.eurekalert.org/pub_releases/2010-11/iuso-awg110110.php (accessed January 15, 2011).
[76] Kaiser EDU, "Medical Malpractice Policy," The Henry J. Kaiser Family Foundation, May 2005, http://www.kaiseredu.org/Issue-Modules/Medical-Malpractice-Policy/Background-Brief.aspx (accessed June 13th, 2011).

A low level state like Minnesota charges general surgeons between $11,000 and $13,000 a year in premiums.[77] The middle level states have premium costs with a fairly sizeable range. The lower premium cost middle level states, such as Tennessee and Kentucky, have general surgeon averages from $35,000 to $55,000 while higher premium spots include Wyoming and the District of Columbia with ranges of $59,000 to $73,000 on premiums a year.[78] Higher premium states like Florida and New York have different premium levels depending on the county you live in. A general surgeon in Nassau county New York can face a premium of up to $106,000 a year while a general surgeon in the Seneca county area will only have to pay around $30,000 a year.[79] Florida follows the same pattern. A general surgeon in the Miami-Dade county area can expect to pay around $115,000 to $190,000 while the lower county fees are around $90,000 a year.[80] The average case settlement cost in 2002 was $320,000 dollars according to the Congressional Budget Office.[81] A common fear attached with malpractice suits is that they are driving up the costs of health care substantially. This is not the case. In fact, a study found that all the malpractice insurance and settlements for the year 2010 cost

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[77] Michael Matray, "Minnesota: Physician Medical Malpractice Insurance Rates," Medical Malpractice Monitor, 2009, http://mymedicalmalpracticeinsurance.com/minnesota-medical-malpractice-insurance.php#historicdata (accessed April 19th, 2011).

[78] Michael Matray, "Medical Malpractice Insurance Rates by State," Medical Malpractice Monitor, 2009, http://mymedicalmalpracticeinsurance.com/medical-malpractice-insurance-rates.php (accessed April 19th, 2011).

[79] Michael Matray, "New York: Physician Medical Malpractice Insurance Rates," Medical Malpractice Monitor, 2009, http://mymedicalmalpracticeinsurance.com/new-york-medical-malpractice-insurance.php#historicdata (accessed April 19th, 2011).

[80] Michael Matray, "Florida: Physician Medical Malpractice Insurance Rates," Medical Malpractice Monitor, 2009, http://mymedicalmalpracticeinsurance.com/florida-medical-malpractice-insurance.php#historicdata (accessed April 19th, 2011).

[81] Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," January 8th, 2004, http://www.cbo.gov/doc.cfm?index=4968&type=0 (accessed January 15th, 2011).

"$55.6 billion per year, or about 2.4 percent of annual health care spending."[82] While malpractice suits are only a small fraction of overall health care costs the price of malpractice insurance costs are still high.

RED TAPE

The government and insurance companies affect health care directly through their procedures. These procedures are known as red tape. Red tape is an "excessive bureaucracy or adherence to rules and formalities, especially in public business."[83] Red tape or excessive rules are known to add time and money to procedures. The United Health Group came up with several conclusions on how to fix the red tape issues. They called for "tighter mandatory data and transaction standards, elimination of antiquated manual processes, automated payment accuracy processes across the health care system, a single credentialing and quality measurement process, and a sophisticated and consistent regulatory regime."[84] Simply put, the United Health Group pushed for a more up to date, streamlined, and efficient method of dealing with data, paper work, and money to cut red tape. The top three cost saving methods were to "eliminate paper checks and paper remittance advice in favor of electronic funds transfer and electronic remittance advice, use predictive modeling to pre-score claims for coordination of benefits, up coding, subrogation, fraud and medical management prior to payment, [and to] create a national payment accuracy clearinghouse to settle under-payments and over-

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[82] Julie Rovner, "Study: Malpractice Costs Just a Tiny Fraction of Health Spending," Kaiser Health News, Sept 7, 2010, http://www.kaiserhealthnews.org/Stories/2010/September/07/malpractice-costs-overstated-npr-shorttake.aspx (accessed January 20, 2011).

[83] Abate, Frank, "Red Tape," *The Oxford Desk Dictionary and Thesaurus: American Edition*, (Berkley Books: New York, 1997), p. 668.

[84] UnitedHealth Group, "Health Care Cost Containment- How Technology Can Cut Red Tape and Simplify Health Care Administration," UnitedHealth Center for Health Reform and Modernization, June 2009, http://www.unitedhealthgroup.com/hrm/unh_workingpaper2.pdf (accessed November 16th, 2010), p.4.

payments."[85] Each of these three methods could cause savings of more than $40 billion by the year 2019 if enacted now. Subrogation is "the substitution of one person in the place of another with reference to a lawful claim or right . . . subrogation commonly occurs in insurance matters, when an insurance company which pays its insured client for injuries and losses then sues the party which the injured person contends caused the damages to him/her."[86] UnitedHealth Group also proposed eliminating the use of paper and to use electronic methods for checks and remittance. The study found that "mandating electronic payments adoption . . . could save the U.S. health care system an estimated $109 billion over the next 10 years."[87] The small changes in red tape policies save the United States health care industry billions. How close are we to achieving these reforms of red tape? Electronic payments have been listed in the CFR which is the Code of Federal Regulations. The Department of Health and Human Services put forth a regulation in 2000 that "adopts standards for eight electronic transactions and for code sets to be used in those transactions" and that "the use of these standard transactions and code sets will improve the Medicare and Medicaid programs and other Federal health programs and private health programs, and the effectiveness and efficiency of the health

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[85] UnitedHealth Group, "Health Care Cost Containment- How Technology Can Cut Red Tape and Simplify Health Care Administration," UnitedHealth Center for Health Reform and Modernization, June 2009, http://www.unitedhealthgroup.com/hrm/unh_workingpaper2.pdf (accessed November 16th, 2010), p.5.
[86] USLegal, "Subrogation Law and Legal Definition," USLegal.com, http://definitions.uslegal.com/s/subrogation/ (accessed November 16th, 2010).
[87] UnitedHealth Group, "Health Care Cost Containment- How Technology Can Cut Red Tape and Simplify Health Care Administration," UnitedHealth Center for Health Reform and Modernization, June 2009, http://www.unitedhealthgroup.com/hrm/unh_workingpaper2.pdf (accessed November 16th, 2010), p.8.

care industry in general, by simplifying the administration of the system and enabling the efficient electronic transmission of certain health information."[88]

Eliminate paper checks and Paper Remittance Advice in favor of electronic funds transfer and electronic remittance advice.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	1.5	1.8	2.2	2.5	8.0	21.7
Provider	0.0	6.1	7.3	8.6	10.0	32.0	86.9
Total	**0.0**	**7.6**	**9.1**	**10.8**	**12.5**	**40.0**	**108.6**

Figure 2.8. Eliminate Paper Checks and Paper Remittance Advice in Favor of Electronic Funds Transfer and Electronic Remittance Advice, 2010-2019. Source: UnitedHealth Center for Health Reform and Modernization, *Health Care Cost Containment: How Technology Can Cut Red Tape and Simplify Health Care Administration* (UnitedHealth Group, June 2009).

[88] Department of Health and Human Services, "Health Insurance Reform: Standards for Electronic Transactions," August 17th, 2000, Federal Register, vol. 65, no. 160, http://aspe.hhs.gov/admnsimp/final/txfin00.htm (accessed June 20th, 2011).

CHAPTER 3

HEALTH INSURANCE

Health insurance has steadily risen in cost over recent years. The increase has put pressure on Americans that are trying to pay their medical bills. The employer based health insurance has glaring faults such as the inability of workers to transfer their insurance wherever they go. The reader will learn how health insurance works and how employee based health care dominates the health insurance field.

HOW HEALTH INSURANCE WORKS

Health insurance is relatively unique in how it interacts with individuals. Discovery Health states that one health insurance principle is based on the consumer "paying a premium every month just in case something happens."[89] Health insurance is similar to auto, home and life insurance in the fact that all four insurance types have a premium that the holder of the policy must pay. The next part of health insurance is "the amount of your bill that the insurance company will pay, and under what circumstances they'll pay it is known as coverage and can vary greatly from policy to policy."[90]

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[89] Lee Ann Obringer and Melissa Jeffries, "How Health Insurance Works," Discovery Health, February 04, 2006, http://health.howstuffworks.com/medicine/healthcare/insurance/health-insurance1.htm (accessed November 18th, 2010), p.2.

[90] Lee Ann Obringer and Melissa Jeffries, "How Health Insurance Works," Discovery Health, February 04, 2006, http://health.howstuffworks.com/medicine/healthcare/insurance/health-insurance1.htm (accessed November 18th, 2010), p.2.

Coverage can include annual checkups by physicians and normal preventative care. Contracts are negotiations or written policies that decide how much the insurance companies and how much an individual pays for medical care. These payments are then split into such areas as co-payments and deductibles. Co-payments are "a cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service."[91] Co-payments are used most often for prescription drugs and clinical care services. For example, an individual with a $20 dollar co-payment would pay that $20 dollars every time they visited their doctor. Deductibles are "amounts required to be paid by the insured under a health insurance contract, before benefits become payable" and are "usually expressed in terms of an 'annual' amount."[92] Deductibles work by individuals paying a certain amount of a medical payment and the insurance companies paying the rest of the cost. For example, an individual with a $2,000 dollar deductible would pay the first $2,000 dollars on a $10,000 dollar charge. The insurance companies would pay the remaining $8,000 dollar charge. The other factor with deductibles is that once the deductible limit is met for the year, the insurance will cover other medical costs covered by the insurance plan.

Health insurance companies are an integral part of the health care system. They control the payment methods for the system. When a consumer buys an insurance plan to cover medical expenses they buy them from insurance companies. The premiums for these plans cost around $4,000 dollars for single individuals and over $13,000 dollars for

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[91] Pat Ricks, "Co-Payment Versus Co-Insurance What's in Your Pocket?," Hereford Physical Therapy and Sports Medicine, http://www.herefordpt.com/copayment.shtml (accessed November 18th, 2010).
[92] Pat Ricks, "Co-Payment Versus Co-Insurance What's in Your Pocket?," Hereford Physical Therapy and Sports Medicine, http://www.herefordpt.com/copayment.shtml (accessed November 18th, 2010).

family premiums in 2009.[93] These plans cover anything from physical therapy sessions, to local medical clinics and to hospital stays. Health insurance premium costs have continued to rise. Health insurance premiums in the year 1999 were around $2,000 dollars for singles and $5,000 dollars for families.[94] This means that premium costs doubled in only ten years. The elderly face an even harsher situation than the average individual. The Agency for Health Care Research and Quality found that "the average health care expense in 2002 was $11,089 per year for elderly people but only $3,352 per year for working-age people (ages 19-64)."[95] The total cost of private health insurance premiums for the year 2009 was $808.7 billion dollars.[96]

HOW HEALTH INSURANCE IS PROVIDED

A discussion of how health insurance is provided will give an idea of how the health care market works. The current health insurance market has only limited free market ideals instead of a truly free market setup. Health insurance is provided through two main methods. These are the public and the private methods. The current format has weaknesses when addressing individual control of health insurance. The largest public

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[93] National Conference of State Legislatures, "Health Insurance: Premiums and Increases," NCSL, http://www.ncsl.org/Default.aspx?TabId=14514 (accessed November 16th, 2010).
[94] National Conference of State Legislatures, "Health Insurance: Premiums and Increases," NCSL, http://www.ncsl.org/Default.aspx?TabId=14514 (accessed November 16th, 2010).
[95] Mark W. Stanton, "The High Concentration of U.S. Health Care Expenditures," AHRQ U.S. Department of Health and Human Services, http://www.ahrq.gov/research/ria19/expendria.htm (accessed July 8th, 2011).
[96] Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2009-2019," U.S. Department of Health and Human Services, September 2010, http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf (accessed June 15th, 2010), p.2.

health care insurers are through the federal government and the state governments.[97] The government run health care options include "Medicare, Medicaid, federal and state employee health plans, the military, and the Veterans Administration."[98] A newer area of government health insurance is allowing states to control Medicare and Medicaid in its borders. One example of this state control of Medicaid is TennCare. TennCare "is the State of Tennessee's expanded Medicaid program that provides health care for 1.2 million Tennesseans and operates with an annual budget of approximately seven billion dollars."[99] The next area of coverage is from private health insurers. The majority of people get their health coverage through private insurance as over 194 million people were insured through private means in 2009 out of a total 253 million people with insurance that same year.[100] Private insurance is further broken down into "state-licensed health insuring organizations and self-funded employee health benefit plans."[101] There are three main state licensed health insurance programs. They are commercial health insurers, Blue Cross and Blue Shield plans, and Health Maintenance Organizations

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[97] Lee Ann Obringer and Melissa Jeffries, "How Health Insurance Works," Discovery Health, February 04, 2006, http://health.howstuffworks.com/medicine/healthcare/insurance/health-insurance1.htm (accessed November 18th, 2010), 4.

[98] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed November 20th, 2010).

[99] TennCare, "TennCare Overview," TN.gov, http://www.tn.gov/tenncare/news-about.html (accessed November 22nd, 2010).

[100] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238,*Income, Poverty, and Health Insurance Coverage in the United States: 2009*,U.S. Government Printing Office, Washington, DC, 2010, p.30.

[101] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed November 20th, 2010).

(HMO's).[102] The first of the state licensed health insurance organizations are commercial health insurers. Commercial health groups "are generally organized as stock companies (owned by stockholders) or as mutual insurance companies (owned by their policyholders)." Blue Cross and Blue Shield plans are organized under the BCBSA which is more commonly known as the Blue Cross and Blue Shield Association. The BCBSA "is a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies."[103] Blue Cross and Blue Shield companies are unique among state licensed health insurers. Gary Claxton states that Blue Cross and Blue Shield companies "were organized as not-for-profit organizations under special state laws by state hospital (Blue Cross) and state medical (Blue Shield) associations" . . . but "today . . . Blue Cross and Blue Shield plans operate and are regulated in a similar manner to commercial insurers."[104] HMO's are the next state licensed health provider. HMO's, PPO's, and POS's are different insurance plans that a consumer can choose from health care companies and BCBSA companies.[105] HMO's utilize preventative care to alleviate health care costs. This is through the fact that "they seek to reduce health care costs by identifying and treating illness early on, before it becomes a more serious--and costly—situation" and "the HMO functions as a healthcare

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[102] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed November 20th, 2010), p.5.

[103] Blue Cross Blue Shield Association, "About the Blue Cross and Blue Shield Association," BCBSA, http://www.bcbs.com/about/ Accessed November 22th, 2010).

[104] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed April 19th, 2011), p.5.

[105] Blue Cross Blue Shield of North Carolina, "Plans for Medicare Beneficiaries," Blue Cross Blue Shield Association, April 17th, 2011, http://www.bcbsnc.com/assets/shopper/public/medicare-supplement/index.htm (accessed June 13th, 2011).

network" because "aside from emergencies, your Primary Care Physician (PCP) serves as your primary and initial point of contact for all health concerns."[106] Health Maintenance Organizations lower health costs for its users by trying to catch health concerns early and treating that concern by covered doctors. The downside is that your primary care physician must refer you to other covered specialists to receive medical care. In essence, the consumer using an HMO must ask permission to seek the aid of another doctor or specialist. HMO's provide health insurance coverage only when their consumers use the primary care physicians and the other medical entities covered under the referral system. There are two health insurance methods that are similar to HMO's but are different. These two methods are known as PPO's and POS's. PPO's are commonly known as preferred provider organization plans. PPOs' work as they are "a group system of health care organized by an insurance company . . . physicians, health care providers of all types, hospitals and clinics sign contracts with the PPO system to provide care to its insured people" and "these medical providers accept the PPO's fee schedule and guidelines for its managed medical care."[107] In layman's terms, PPO's are run by a health insurance company that covers a certain amount of costs for their consumers when they visit doctors, other medical personnel, and medical facilities covered by the insurance company. An individual would not be covered with the same rate if they went to a doctor or medical facility outside of those covered by the insurance company. MedHealthInsurance describes how an individual would use other sources other than

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[106] Health Insurance Info, "Health Maintenance Organizations (HMOs)," Health Insurance. Info: The Consumer's Health Insurance Authority, http://www.healthinsurance.info/guide/types/hmo (Accessed November 22nd, 2010).

[107] MedHealthInsurance, "Preferred Provider Organization Plans (PPO Plans)," http://www.medhealthinsurance.com/ppoplan.htm (accessed November 29th, 2010).

those covered by the insurance company with "if the person wants to see an out-of-network doctor, he/she may do so without permission; but the deductible for out-of-network services may be higher and the percentage the insurance will pay may be lower . . . in other words, the patient will be responsible for a greater part of the fee . . . this encourages the people insured with a PPO to use the physicians, other medical providers and hospitals in their network."[108] The goal of the health insurance company using the PPO is that the consumer will generally use the health care providers cover under their insurance but still have a choice to get medical care elsewhere. The final form of commercial health insurance is from POS's. POS's are a point of service plan that allow the consumer to "have a primary care doctor and you get most of your health care from an HMO network" and that the consumer "can choose to see doctors and other providers outside of the HMO network, but you will have to pay a much higher cost than if you stayed in the HMO network."[109] POS plans work like HMO plans in the fact that members are allowed to use non-covered medical facilities but must pay more to use them. In effect, HMO's and PPO's limit portability of health insurance as it costs more to use non-covered providers.

The Kaiser Family Foundation discovered that "private health coverage is provided primarily through benefit plans sponsored by employers."[110] The AHRQ or better known as the Agency for HealthCare Research and Quality states that "employer-

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[108] MedHealthInsurance, "Preferred Provider Organization Plans (PPO Plans)," http://www.medhealthinsurance.com/ppoplan.htm (accessed November 29th, 2010).
[109] CalHealth.Net, "California PPO and POS Plans," http://www.calhealth.net/california_PPO_POS_health_insurance.htm (accessed November 29th, 2010).
[110] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf (accessed November 20th, 2010).

based health insurance market provided insurance to over 159 million Americans who constitute nearly two-thirds (63.4 percent) of the population under sixty-five" in the year 2003.[111] The number of people on employer based health care has increased since that time. The current number of people on employer based health care was 169 million people in 2009.[112] Employer based health insurance is not for everyone though. The AHRQ also found the most common types of people that are the least likely to have employer based health insurance. These sections of the population were "workers in small establishments, minorities especially Hispanic males, young adults ages 19 through 24, near-elderly working women with health problems, and retirees."[113]

WHO ARE THE TOP PROVIDERS?

As mentioned above, health care is provided by public and private entities. What has not been discussed is the amount of people covered by health insurance and what businesses or entities cover the most people. A discussion of health care is not complete without an overview of the total number of people covered by health insurance. The United States Census Bureau found that in 2009 around 253 million people in the United States were covered by health insurance.[114] This means that the majority of Americans do have some form of health insurance. The recent focus of health care reform in America has been on the amount of people that are not covered by health insurance. The United

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[111] Mark W. Stanton, "Employer-Sponsored Health Care," AHRQ, http://www.ahrq.gov/research/empspria/empspria.htm (accessed November 23th, 2010).

[112] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238,*Income, Poverty, and Health Insurance Coverage in the United States: 2009*,U.S. Government Printing Office, Washington, DC, 2010, p.24.

[113] Mark W. Stanton, "Employer-Sponsored Health Care," AHRQ, http://www.ahrq.gov/research/empspria/empspria.htm (accessed November 23th, 2010).

[114] Carmen DeNavas-Walt , Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, Washington, DC, 2010, p.22.

States Census Bureau reported that 46.3 million people did not have health insurance in 2008.[115] Many Americans see this level of uninsured as too high for an industrialized country like the United States. This becomes especially true when the United States is compared to European countries. Most European countries have universal health care. Universal health care countries in Europe include Germany, Ireland, Norway, the United Kingdom, Netherlands, Austria, Denmark, Greece, Portugal, Italy, Belgium, Iceland, Luxemburg, France, Spain, and Finland.[116] Universal health care is also national health care. Therefore, most of the people that live in those countries have their health care covered by the national government by public methods and the rest of the people covered by private providers. Many of these countries use higher tax rates to help pay for the national health care systems within their borders. Thus, universal health care countries allow individuals from other countries to use their hospital and preventative medical services for free. One major provider area in the United States is public health insurance. The largest provider of public health insurance is the federal government. The federal government provides health insurance mainly through two programs. These two programs are Medicaid and Medicare. Medicare is for people over the age of 65 and for some people with qualifying disabilities. Medicaid is for poor individuals and families and for people with disabilities. Medicare enrolled over 43 million people while

[115] Richard Pizzi, "Number of People without Health Insurance Rises," Health Care Finance News, September 11th, 2009, http://www.healthcarefinancenews.com/news/number-people-without-health-insurance-rises (accessed November 26th, 2010).
[116] Ian T. Brown and Christopher Khoury, "In OECD Countries, Universal Health Care Gets High Marks," Gallup.com, http://www.gallup.com/poll/122393/oecd-countries-universal-healthcare-gets-high-marks.aspx (accessed November 27th, 2010).

Medicaid enrolled over 47 million people during 2009.[117] This means that over 90 million people rely on government provided health insurance. The next area of health insurance is the state licensed programs. The largest representative of state licensed health programs is the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association reports that it "collectively provide[s] healthcare coverage for nearly 100 million people across all 50 states."[118] The final providers of health insurance are the employer based health insurance policies. These policies are provided by health insurance companies. The year 2009 saw over 169 million people use employer based health insurance.[119] Many of the employer based health insurance companies are commercial entities that are listed on the stock market. In fact, some of these commercial health insurance companies rank within the Fortune 500 rankings. The Fortune 500 ranking is a listing of the top U.S. companies by profit. The top three commercial health insurance companies by profit are the UnitedHealth Group, WellPoint, and Aetna. These three health insurance providers rank within the top 70 of the Fortune 500 companies. The largest health insurance provider by profit was the UnitedHealth Group. The UnitedHealth Group covers over 30 million people in the United States and over 75 million people worldwide with their health insurance.[120] The company uses six companies under its control to administer the health care programs to its consumers.

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[117] Carmen DeNavas-Walt , Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, Washington, DC, 2010, p.24.

[118] Blue Cross Blue Shield Association, "Investing in America's Health-2009 Report," BCBSA, http://www.bcbs.com/about/investing-in-americas-health/ (Accessed November 27th, 2010).

[119] Carmen DeNavas-Walt , Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, Washington, DC, 2010, p.24.

[120] UnitedHealth Group, "About," http://www.unitedhealthgroup.com/Main/AboutUs.aspx (accessed November 29th, 2010).

These six companies are "UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, OptumInsight, and OptumRx."[121] The second largest health insurance by profit was WellPoint. WellPoint provides health insurance to over 33 million people in the United States.[122] WellPoint also works alongside Blue Cross and Blue Shield programs across several states.

Fortune 500 Industries: Health Care: Insurance and Managed Care

			Revenues		Profits	
Rank	**Company**	**Fortune 500 rank**	**$ millions**	**% change from 2008**	**$ millions**	**% change from 2008**
1	UnitedHealth Group	21	87,138.00	7.3	3,822.00	28.4
2	WellPoint	31	65,028.10	6.2	4,745.90	90.5
3	Aetna	63	34,764.10	12.3	1,276.50	-7.8
4	Humana	73	30,960.40	7	1,039.70	60.7
5	Cigna	129	18,414.00	-3.6	1,302.00	345.9
6	Health Net	146	15,713.20	2.3	-49	-151.6
7	Coventry Health Care	168	13,993.30	17.5	242.3	-36.6
8	WellCare Health Plans	328	6,878.20	5.5	39.9	N.A.
9	Amerigroup	404	5,188.10	14.9	149.3	N.A.
10	Universal American	425	4,963.50	6.5	140.3	47.5
11	Centene	486	4,248.00	20.8	83.7	0.2

Issue date: May 3, 2010.

[121] UnitedHealth Group, "About," http://www.unitedhealthgroup.com/Main/AboutUs.aspx (accessed June 13th, 2011).
[122] WellPoint, "Our Business," http://www.wellpoint.com/business/default.asp (accessed November 29th, 2010).

Figure 3.1. Health Care: Insurance and Managed Care. 2010. Source: Fortune, *Fortune 500: Industries* (CNN Money, May 3rd 2010).

Employee based health insurance does not work as well as it should. Paul Krugman and Robin Wells state that "the whole system of employer-based health care is under severe strain . . . we can identify several reasons for that strain, but mainly it comes down to the issue of costs."[123] The cost of health insurance under employee control is expensive for many Americans. Krugman and Wells continue with "health care costs at current levels override the incentives that have historically supported employer-based health insurance."[124] A solution must be implemented that can fix the employer system's weaknesses.

[123] Paul Krugman and Robin Wells, "The Health Care Crisis and What to Do About It," The New York Review of Books, February 22nd, 2006, http://www.nybooks.com/articles/archives/2006/mar/23/the-health-care-crisis-and-what-to-do-about-it/?page=1 (accessed April 22nd, 2011), p.2.
[124] Paul Krugman and Robin Wells, "The Health Care Crisis and What to Do About It," The New York Review of Books, February 22nd, 2006, http://www.nybooks.com/articles/archives/2006/mar/23/the-health-care-crisis-and-what-to-do-about-it/?page=1 (accessed April 22nd, 2011), p.2.

CHAPTER 4

CONSUMER DRIVEN HEALTH CARE

One alternative may be to fix the issue of massive health care costs and the weaknesses of employer based health care are through consumer-driven health care. Consumer-driven health plans are the insurance plans under a consumer-driven health care system. Consumer-driven health plans are "used to describe a variety of mechanisms for providing health insurance or funding healthcare costs, all of which encourage individuals to become actively involved in making their own healthcare decisions (e.g., designing their health insurance coverage, choosing their service providers, selecting healthcare services, and managing their own fitness and wellness)."[125] A Business Group Health informative release stated that "old managed care may have run its course . . . consumer-driven health care may result in reduced health care costs and improved quality of health care by requiring consumers to take charge of their health care decisions."[126] The Business Group Health release continues with three points as to what consumer health care should be. The first way the Business Group Health list is "transforming the

[125] Lorman Business Center, Inc., "CDHP: Consumer-Driven Health Plans," HR Resource, 2011, http://www.hrresource.com/industry-terms/CDHP/ (accessed May 4th, 2011).
[126] Business Group Health, *Consumer-Driven Health Care for Children: An Employer's Guide to Developing Child and Adolescent Benefits*, "What are Consumer-Driven Health Care Plans?" National Business Group on Health, 2011, http://www.businessgrouphealth.org/pdfs/cdhealthcare_children/section1.pdf (accessed May 2nd, 2011), p. 1.

third-party reimbursement system into one that puts economic purchasing power — and decision-making — in the hands of the consumer."[127] Simply put, the people should control the money that they spend on health care instead of the government or employers. The second way to have consumer-driven health care is through "supplying the information and decision support tools needed, along with financial incentives, rewards and other benefits that encourage personal involvement in altering health and health care purchasing behaviors."[128] The government and the employers must educate people on more effective routs of health care and give the people tax breaks and other benefits to invite them to control their own medical options. The third and final way to gain consumer health care is through "letting consumers, rather than health plans, control health care decisions."[129] The health plans should not control how a person receives health care but a person should control what their health plan covers.

Regina Herzlinger is a professor at the Harvard Business School and is a respected researcher on health care. Regina Herzlinger goes a step farther than Business Group Health and envisions the positive changes that consumer-driven health care will have on the overall health care system. She describes three main changes that would occur to the health care system. The first is "health care focused factories will bring

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[127] Business Group Health, *Consumer-Driven Health Care for Children: An Employer's Guide to Developing Child and Adolescent Benefits*, "What are Consumer-Driven Health Care Plans?" National Business Group on Health, 2011, http://www.businessgrouphealth.org/pdfs/cdhealthcare_children/section1.pdf (accessed May 2nd, 2011), p. 2.

[128] Business Group Health, *Consumer-Driven Health Care for Children: An Employer's Guide to Developing Child and Adolescent Benefits*, "What are Consumer-Driven Health Care Plans?" National Business Group on Health, 2011, http://www.businessgrouphealth.org/pdfs/cdhealthcare_children/section1.pdf (accessed May 2nd, 2011), p. 2.

[129] Business Group Health, *Consumer-Driven Health Care for Children: An Employer's Guide to Developing Child and Adolescent Benefits*, "What are Consumer-Driven Health Care Plans?" National Business Group on Health, 2011, http://www.businessgrouphealth.org/pdfs/cdhealthcare_children/section1.pdf (accessed May 2nd, 2011), p. 2.

specialists and generalists into one integrated "stop-and-shop" system of care."[130] This means that individuals will pick their health insurance options and pick their own doctors in one place and time. The second change is "consumer-based medical records will create one information access point for patients and providers."[131] As discussed earlier with electronic records and payments, consumer-based medical records will simplify access to medical data and lower heath care costs. The third change would be "medical technology will be personalized for the needs of individual patients."[132] This means that an individual receives specialized care for their needs and symptoms such as specialized medicines that work best for one patient but not another.

There are three main ways to provide and to encourage consumer-driven health care plans. These three methods are tax incentives, employer funded individual health care plans, and HSA's. The creation of tax incentives for those with consumer-driven health plans is a first step in making individual health care more affordable. These tax enticements would be created by the federal government. The federal government then would be able to ensure equal tax opportunities for all Americans that use consumer-driven health plans. Regina Herzlinger describes this action with "the U.S. Congress will

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[130] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "How Consumer-Driven Health Care Will Change the Supply of Health Care Services," New York, New York: McGraw-Hill, p.167.
[131] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "How Consumer-Driven Health Care Will Change the Supply of Health Care Services," New York, New York: McGraw-Hill, p.167.
[132] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "How Consumer-Driven Health Care Will Change the Supply of Health Care Services," New York, New York: McGraw-Hill, p.168.

pass laws that enable you to buy your health insurance with tax-free income."[133] This means the government writes off all the money the individual uses towards healthcare from the money that is taxable. One of the current ways consumer-driven health care deals with tax money is through pre tax accounts. In fact, the Bureau of Labor Statistics states that "the combination of a pretax payment account with a high-deductible health plan is what is commonly referred to as a *consumer-driven health plan* (CDHP)" and that "the first tier is a pretax account that allows employees to pay for services using pretax dollars."[134]

The provision of employer funded individual health plans is the second method to develop consumer-driven health care. The current health care situation, as discussed in the previous chapter, is based on employer provided health care where the employers pick the insurance plans employees must follow. An article in the Journal of Business Administration Online reported that "under managed care systems, the employer plan restricts choice by dictating which doctors and other providers are available to employees . . . with a limited choice of providers, there is no pressure on the plan to be responsive."[135] Employers do help fund employer based health plans. Employer funded plans are different from employer provided plans when dealing with consumer-driven health care. Consumer-driven employer funded plans arise when the company provides

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[133] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "How Consumer-Driven Health Care Will Change the Supply of Health Care Services," New York, New York: McGraw-Hill, p. 248.

[134] Song G. Yi, "Consumer-Driven Health Care: What is it and What Does It Mean for Employees and Employers?" Bureau of Labor Statistics, October 25th, 2010, http://www.bls.gov/opub/cwc/cm20101019ar01p1.htm (accessed May 12th, 2011).

[135] Robert Hayes, Kenneth Hollman, and Emily Zietz, "A New Paradigm To Control Health Care Costs: Consumer Driven Health Care Plans," Fall 2004, Vol. 3, no. 2, http://www.atu.edu/business/jbao/Fall2004/HollmanJBAOF2004.pdf (accessed June 15th, 2011), p. 8.

monetary support for their employees individual health plans. These plans "may be funded by the employer or the employee, depending on the type of account."[136]

The last method to provide consumer-driven health plans is through HSA's. HSA's are better known as health savings accounts. HSA's and most other consumer-driven plans work by the utilization of a pre tax account along with a high deductible health plan. Health savings accounts have a unique use of the pre tax accounts as "any unused amount in this account will not be lost at the end of the year . . . rather, the unused amounts will rollover to the next year without a penalty."[137] The IRS currently has very strict guidelines on who can use an HSA through the use of high deductible insurance plans. HDHP stands for high deductible health plans. The Bureau of Labor Statistics states that "the Internal Revenue Service (IRS) has placed rules and guidelines for HDHPs to be qualified . . . the HDHP must meet the following requirements: as of 2009, the IRS defines an HDHP as a health plan with a minimum yearly deductible of $1,150 for an individual and $2,300 for a family; and the annual maximum out-of-pocket expense cannot exceed $5,800 for an individual and $11,600 for a family."[138] HRA's are known as both health reimbursement arrangements and health reimbursement accounts. The IRS reports that "a health reimbursement arrangement (HRA) must be funded solely by an employer" and that "there are no reporting requirements for HRAs on your income

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[136] Song G. Yi, "Consumer-Driven Health Care: What is it and What Does It Mean for Employees and Employers?" Bureau of Labor Statistics, October 25th, 2010, http://www.bls.gov/opub/cwc/cm20101019ar01p1.htm (accessed May 12th, 2011).
[137] Song G. Yi, "Consumer-Driven Health Care: What is it and What Does It Mean for Employees and Employers?" Bureau of Labor Statistics, October 25th, 2010, http://www.bls.gov/opub/cwc/cm20101019ar01p1.htm (accessed May 12th, 2011).
[138] Song G. Yi, "Consumer-Driven Health Care: What is it and What Does It Mean for Employees and Employers?" Bureau of Labor Statistics, October 25th, 2010, http://www.bls.gov/opub/cwc/cm20101019ar01p1.htm (accessed May 12th, 2011).

tax return."[139] This means that the HRA is not a taxed item thereby saving the individual money. Archer medical savings accounts (MSA's) are the final current form of consumer-driven health plans. MSA's "were created to help self-employed individuals and employees of certain small employers meet the medical care costs of the account holder, the account holder's spouse, or the account holder's dependent(s)," and are "a tax-exempt trust or custodial account that you set up with a U.S. financial institution (such as a bank or an insurance company) in which you can save money exclusively for future medical expenses." All three of the current consumer-driven health care plans have restrictions controlling who the individual on the plans are. These restrictions come in the form of limits on who can contribute to the accounts, a qualifying high deductible health plan, and no other form of health insurance.

Blue Cross Blue Shield stated that "health insurance works best when it's the right fit for your health and your finances."[140] In other words, a health insurance plan that is tailored to the individual buying the plan will get more out of it money and efficiency wise. The American Health Insurance Plans organization concurred this in a 2004 study. AHIP found that "individually purchased major medical insurance was more affordable and accessible than may be widely known, and offered a broad array of benefits . . . most applications for coverage were approved with no restrictions, and the benefits commonly purchased by consumers provided substantial financial protection."[141] Short term

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[139] IRS.Gov, 2010, *Publication 969*, "Health Reimbursement Arraignments (HRA's)," Internal Revenue Service , http://www.irs.gov/publications/p969/ar02.html#en_US_2010_publink1000204194 (accessed May 12th, 2011).

[140] Blue Cross Blue Shield, "Individual and Family Plans," Blue Cross Blue Shield of North Carolina, 2010, http://www.bcbsnc.com/content/plans/individuals/index.htm (accessed April 20th, 2011).

[141] Thomas F. Wildsmith, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," AHIP Center for Policy and Research, August 2005,

COBRA plans are different than other consumer driven health care plans. This difference arises from the fact that "the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as 'qualifying events')."[142] Therefore, COBRA plans are like severance packages as they provide temporary insurance until a more permanent plan is purchased. The impermanence of COBRA plans is further reinforced by the fact that plans last "up to 18 months for covered employees, as well as their spouses and their dependents, when workers otherwise would lose coverage because of a termination or reduction of hours," and at the longest "up to 36 months for spouses and dependents facing a loss of employer-provided coverage due to an employee's death, a divorce or legal separation, or certain other 'qualifying events'."[143]

PORTABILITY

One of the key issues of health insurance is that it is not portable. The portability of health insurance is a growing issue. Portability is defined as anything that is "capable of being transported or conveyed."[144] For health insurance, the word portable is used to describe the movement of health insurance policies from employer to employer. Health

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http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf (accessed April 22nd, 2011), p.1.

[142] COBRA Insurance.net, "COBRA Questions and Answers," 2008, http://www.cobrainsurance.net/COBRA_Health_Insurance/COBRA_Insurance_Questions.htm (accessed June 15th, 2011).

[143] COBRA Insurance.net, "COBRA Questions and Answers," 2008, http://www.cobrainsurance.net/COBRA_Health_Insurance/COBRA_Insurance_Questions.htm (accessed June 15th, 2011).

[144] Dictionary.com, "Portable," http://dictionary.reference.com/browse/portable (accessed November 29th, 2010).

insurance, as it stands now, is not easily portable. This is due to health insurance plans not being in the hands of individuals but in the control of insurance or employer entities.

As people switch jobs more often, the insurance people use is not traveling with them. This is due to the fact that most health insurance plans are controlled by employer based coverage. Currently, 169 million people use employer based health insurance.[145] Most of those individuals would lose their insurance if they switched to other companies. The individual also faces the possibility that when they move to another company that they will not have all the same benefits as before. Even health plans with multiple entities like HMO's and PPO's limit the options of consumers to move their health insurance plan to other medical facilities outside those covered by the providers. The problem arises when an individual cannot keep their health insurance from one company when they transfer to another company. John Goodman is the president of the National Center for Policy Analysis which is a nonpartisan organization with the goals of free market solutions to fix health care. A 2006 letter written by Dr. Goodman addresses the issue of portability as "employees who switch jobs must not only switch health plans but also doctors, since plans tend to have their own network . . . additionally, different plans have different benefit packages, meaning services such as mental health may be covered under one employer's plan but not another's."[146] He goes on to encourage employers to have a form of portable insurance as it will benefit them and their employees. John Goodman explains that "competition for workers could induce employers to offer portable health

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[145] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, Washington, DC, 2010, p.24.

[146] John Goodman (2006), "Employer-Sponsored, Personal, and Portable Health Insurance" *Health Affairs*, 25(6), 1556-1566, http://content.healthaffairs.org/content/25/6/1556.full#R2 (accessed November 29th, 2010).

benefits, even if they were not otherwise inclined to do so."[147] He uses the argument that the portability of insurance for employees will benefit the employer in the long run due to the financial gains and better quality of workers even if they have high medical risks. What has been done to rectify this matter? The United States government took action in 1996 and formed HIPAA to deal with portability. HIPAA stands for Health Insurance Portability and Accountability Act. The Department of Labor defines HIPAA as providing "rights and protections for participants and beneficiaries in group health plans . . . includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances . . . HIPAA may also give you a right to purchase individual coverage if you have no group health plan coverage available."[148] HIPAA was created to protect individuals even to the point of creating plans for those individuals. The organization is now known for patient privacy laws. These patient privacy laws limit the amount of people that can access an individual's health care information and restricts the purposes for access. John Goodman argues that HIPAA no longer lives up to the portability listed in its name. Goodman states that "despite its stated intent, however, the Health Insurance Portability and Accountability Act (HIPAA) strongly discourages

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[147] John Goodman (2006), "Employer-Sponsored, Personal, and Portable Health Insurance" *Health Affairs*, 25(6), 1556-1566, http://content.healthaffairs.org/content/25/6/1556.full#R2 (accessed November 29th, 2010).

[148] Secretary of Labor Hilda L. Solis, "Health Plans and Benefits: Portability of Health Coverage (HIPAA)," Department of Labor, http://www.dol.gov/dol/topic/health-plans/portability.htm (accessed December 1st, 2010).

individually owned, portable insurance."[149] The recent Affordable Health Care Act of 2010 allows for limited amounts of portability. Section 114 of the Affordable Health Care Act lists that "STATE INSURANCE EXCHANGES.—State insurance exchanges that develop new, less expensive, portable benefit packages for small employers and part-time and seasonal workers," ensuring limited amounts of portability. [150] The parameters do not reference full-time employees leaving their ability to have portable insurance through state exchanges up to interpretation. The bill does say that small employers and part-time employees can have portable insurance under state insurance exchanges. The allowance of portable insurance under the new law is one step toward more portable health insurance.

HEALTH INSURANCE COMPANIES: DO THEY PLAY NICE WITH OTHERS?

Health insurance companies, for the most part, attempt to lower costs for their consumers. But, they also raise certain costs on different organizations. For instance, a 2009 study found that physicians reported "that overall the costs of interacting with health insurance plans is $31 billion annually."[151] This was cost was mainly due to paperwork revolving around bills and claims and quality data. The paperwork was for the health insurance companies about their clients.

Health insurance companies played a major role in the health care reform debate. The health insurance companies directly affected the debate by what they chose to

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[149] John C. Goodman, "Employer-Sponsored, Personal, and Portable Health Insurance," *Health Affairs* vol. 25, no.6, 2006, p.1556-1566.
[150] Affordable Health Care Act 2010, S. 114, 111th Congress (2010).
[151] Robert Wood Johnson Foundation, "Physician Practice Interactions with Health Plans Cost $31 Billion a Year, Equaling 6.9 Percent of All Spending for Physician and Clinical Services, New Study Finds," Robert Wood Johnson Foundation, published May 14th, 2009, http://www.rwjf.org/coverage/product.jsp?id=42728 (accessed November 13th, 2010).

support or attempted to defeat in the bill. AHIP was one such group that defended and proposed some of its own ideas for reform but was also was able to disagree with some parts of the reform. AHIP or better known as American Health Insurance Plans is one of the largest health insurance company associations. AHIP supported the idea of a reform bill with "the health plan community is united in support of comprehensive health care reform that ensures all Americans have high-quality, affordable health care."[152] This shows that the health insurance companies agree with the basic concepts of the health care reform. AHIP advocated for help to lower income individuals that would pay for health care insurance. The help AHIP supported was "individuals from low- and middle-income families who are being asked to participate in the health insurance system will require health care tax credits . . . additionally, it is critical to provide tax equity for those without access to employer coverage . . . these tax reforms will further encourage individuals to purchase and retain coverage over the long term."[153] AHIP wants to ensure that lower income individuals can afford health care. The motivation for AHIP to act this way is so that these individuals will buy the insurance and stick with the insurance for many years thereby earning insurance companies more money. AHIP agreed with several portions of the health care bill such as the belief "that all Americans, regardless of health status or medical history, should have guaranteed access to affordable coverage . . . we have proposed guarantee issue coverage with no exclusions for pre-existing conditions in

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[152] American Health Insurance Plans, "Letter to Senate Finance and Help," American Health Solution, March 24th, 2009, http://www.americanhealthsolution.org/assets/Reform-Resources/Letters-and-Testimony-to-Congress/LettertoSenateFinanceandHELP0324.pdf (accessed December 13th, 2010).
[153] American Health Insurance Plans, "Letter to Senate Finance and Help," American Health Solution, March 24th, 2009, http://www.americanhealthsolution.org/assets/Reform-Resources/Letters-and-Testimony-to-Congress/LettertoSenateFinanceandHELP0324.pdf (accessed December 13th, 2010).

conjunction with a coverage requirement and adequate subsidies for working families."[154] The organization did not agree with several other measures in the bill though. AHIP disagreed with "the new health care taxes and fees" because they "will raise the cost of coverage for individuals, families, and employers" and "this bill will also exacerbate the health care cost shift as health care providers offset reductions in public program reimbursements by charging more to families and employers who have private coverage."[155] The health insurance organization noted the raising of costs as the major criticism of the health care bill. AHIP specifically condemns Congress on costs by stating that "Congress is being forced to turn to these financing mechanisms because it has been unwilling to make a commitment to specific strategies and enforceable objectives that will bend the health care cost curve downward."[156]

Health insurance companies tried to weaken the health care reform by directly and indirectly paying money to groups or people that were against the bill. One group of anonymous insurers paid over $86 million dollars to the United States Chamber of Commerce to oppose the health reform law in late 2009.[157] The U.S. Chamber of Commerce represents different businesses across the United States. The U.S. Chamber of Commerce mainly represents small businesses. Health insurance companies had spent

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[154] American Health Insurance Plans, "AHIP Statement on Release of Proposed Senate Legislation," AHIP, November 19th, 2009, http://www.ahip.org/content/pressrelease.aspx?docid=28807 (accessed December 13th, 2010).
[155] American Health Insurance Plans, "AHIP Statement on Release of Proposed Senate Legislation," AHIP, November 19th, 2009, http://www.ahip.org/content/pressrelease.aspx?docid=28807 (accessed December 13th, 2010).
[156] American Health Insurance Plans, "AHIP Statement on Release of Proposed Senate Legislation," AHIP, November 19th, 2009, http://www.ahip.org/content/pressrelease.aspx?docid=28807 (accessed December 13th, 2010).
[157] Drew Armstrong, "Insurers Gave U.S. Chamber $86 Million Used to Oppose Obama's Health Law," Bloomberg, November 17th, 2010, http://www.bloomberg.com/news/2010-11-17/insurers-gave-u-s-chamber-86-million-used-to-oppose-obama-s-health-law.html (accessed December 13th, 2010).

over $375 million dollars in total lobbying methods on the health care bill by September 2009.[158] The money spent lobbying by September 2009 is just a drop in the bucket compared to health insurance companies overall profits. ABC news reported that "the nation's five largest for-profit insurers closed 2009 with a combined profit of $12.2 billion."[159] Thus, health insurers could become a bigger lobbyist group than they already are.

APPLYING REFORM PRINCIPLES

There are several other reform methods available to fix the current health care situation but none with the cost saving appeal as consumer driven health care. An article in the *Small Business Review* described three methods to fix health care as national health care, savings accounts, and greater individual control.[160] National health care is one of the recent methods in the United States of trying to fix the issues of health insurance. National health care is health care provided to all the population of a nation. This would mean that everyone in that nation would have a health insurance plan to provide them health care. The 2010 health care bill provided for that coverage. The bill is known originally from the House of Representatives as H.R. 3962.[161] The House of

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[158] Jennifer Liberto, "Health Care Lobbying: Political Power Machine" CNN Money.com, http://money.cnn.com/2009/09/08/news/economy/health_care_lobbying/index.htm (accessed December 30, 2010).

[159] Emily Walker, "Health Insurers Post Record Profits," ABC news, February 12th, 2010, http://abcnews.go.com/Health/HealthCare/health-insurers-post-record-profits/story?id=9818699&page=1 (accessed April 20th, 2011), p.1.

[160] Geoff Lewis, "The Twilight of Employer-Sponsored Health Insurance?" *Small Business Review*, January 26th, 2007, http://smallbusinessreview.com/for_the_boss/Employer_Sponsored_Health_Insurance/index.html (accessed June 15th, 2011).

[161] CNN Politics, "House Passes Health Care Reform Bill," cnn.com, November 9th, 2009, http://articles.cnn.com/2009-11-07/politics/health.care_1_affordable-health-care-funds-for-abortion-services-house-democrats?_s=PM:POLITICS (accessed January 10, 2011), p.1.

Representatives passed their version of the health care reform bill on November 7th, 2009. The vote was 220 to 215 in favor of the legislation.[162] March 22nd, 2010 saw the historic signing of the reconciliation of the House of Representatives and the Senate versions of the sweeping health care bill. For many months, Democrats and Republicans had fought for their idea of health care. Eventually, the hard battle ended when a 219 to 212 vote was returned in favor of the legislation.[163] The results of the March vote almost exactly mirrored the vote in November. The health care bill mandated that all American citizens must have health insurance. Individuals that refuse to have health insurance will be fined starting in 2014 at the cost of $750 dollars.[164] The bill officially states "the purpose of this division is to provide affordable, quality health care for all Americans."[165] The use of health insurance had been voluntary in America until the health care bill passed. The new law also ensures that individuals with preexisting conditions cannot be dropped from their insurance.

Health savings accounts are also known as HSA's. HSA's work by an individual or family having a high deductible insurance plan combined with a savings account. The savings account is used to pay the deductible for the insurance plan. The insurance kicks in after the deductible limit is reached. Normally, the insurance covers all of the expenses

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[162] CNN Politics, "House Passes Health Care Reform Bill," cnn.com, November 9th, 2009, http://articles.cnn.com/2009-11-07/politics/health.care_1_affordable-health-care-funds-for-abortion-services-house-democrats?_s=PM:POLITICS (accessed January 10, 2011), p.1.

[163] Shailagh Murray and Lori Montgomery, "House Passes Health Care Reform Bill without Republican Votes," The Washington Post, March 22, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/21/AR2010032100943.html (accessed January 15th, 2011), p.1.

[164] Shailagh Murray and Lori Montgomery, "House Passes Health Care Reform Bill without Republican Votes," The Washington Post, March 22, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/21/AR2010032100943.html (accessed January 15th, 2011), p.2.

[165] House of Representatives, "To Provide Affordable, Quality Health Care for all Americans and Reduce the Growth in Health Care Spending, and for Other Purposes," (111th Congress 1st Session, H.R. 3962) http://docs.house.gov/rules/health/111_ahcaa.pdf (accessed January 3rd, 2010).

once the deductible is reached. The high deductible insurance plans allow for a minimum deductible for singles starting at $1,200 dollars and a minimum starting deductible for families at $2,400 dollars.[166] The individual or family that used an HSA is allowed to keep any extra money in their savings account. The accounts are tax deductible and tax free when used for medical expenses. The highlights of HSA's are that they roll over every year and that they are portable. HSA's save people money through being tax deductible and tax-free.

The final form of reform is through greater individual control of health insurance plans. As stated above, the best way to increase individual control of health insurance is through portability and the ability to choose their own insurance policy tailored to them. Portability is simply the ability of an individual to transfer their health insurance with them from one employer to the next. The current health care system does not allow many employees to have portable insurance. Employers choose the health care company and the plan packages that employees can buy. These plans and the benefits of the health insurance plan given by one employer often only apply to that company. For example, an employee that has worked to have good health insurance benefits with one company must start at the bottom benefits wise at another company. The issue is further complicated by the fact that employers often control the health insurance policies not the individual. Individual health insurance policies are more likely to travel to different companies with the employee keeping the same benefits. Grace-Marie Turner points out that individuals will take better care of their health when they control their own health insurance needs.

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[166] United Healthcare's Golden Rule Insurance Company, "Health Savings Account FAQ's," HAS center.com, http://www.hsacenter.com/faqs.html (accessed January 4, 2011).

She attributes this to increased awareness of individual health needs and individuals controlling their health expenditures.

HOW DO OTHER COUNTRIES DEAL WITH HIGH HEALTH CARE COSTS?

Other countries attempt to lower health care costs in different ways than the United States. Denmark is one such country. They have "annual negotiations between the central government and the regions and municipalities result in agreement on the economic framework for the health sector, including levels of taxation and expenditure . . . the negotiations contribute to control of public spending on health by instituting a national budget cap for the health sector . . . they also form the basis for resource allocation from the central government."[167] This means that all levels of government in Denmark work together to set and control health care prices in the country. Denmark is able to utilize all levels of government as health care is universal in the country. Switzerland is another European country with a different way to deal with health care costs. Switzerland uses universal health care but "is is the consumers themselves who purchase their health insurance," and that "Swiss consumers, not employers or the government, primarily pay for the country's health care expenses."[168] Therefore, Switzerland provides proof of consumer driven health care in action. Regina Herzlinger points out that Switzerland is not a true consumer driven country as "demand

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[167] Karsten Vrangbaek, Isabelle Durand-Zaleski, Reinhard Busse, Niek Klazinga, Sean Boyle, and Anders Anell, "Descriptions of Health Care Systems: Denmark, France, Germany, The Netherlands, Sweden, and the United Kingdom," The Commonwealth Fund, http://www.commonwealthfund.org/~/media/Files/Resources/2008/Health%20Care%20System%20Profiles/LSE_Country_Profiles%20pdf.pdf (accessed July 8th, 2011).

[168] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "Consumer Driven Benefits: Lessons from Other Countries and Industries," New York, New York: McGraw-Hill, p. 194.

is constrained by governmental regulation of the design of insurance policies, and supply is controlled by uniform prices paid to doctors."[169] Dr. Herzlinger continues with "the Swiss lesson is generally a positive one . . . Switzerland provides universal coverage at substantially lower cost than the United States while avoiding the quality, responsiveness, equity, and provider compensation concerns of single-payer universal health care systems."[170] The lesson of Switzerland continues as "the Swiss government only pays for 24.9% of health care costs (compared with 44.7% in the U.S.)" and the "premiums are community rated and only adjusted for sex and age . . . employers do not pay for workers insurance and thus many Swiss have opted for less expensive plans with higher deductibles . . . this has led to the Swiss paying for 31.5% through out of pocket expenses."[171]

CONCLUSION

The American health care system deals with issues such as increased costs, the role of health insurance, and how health insurance should be provided. The increased cost for health care is derived from hospital care and administration, pharmaceutical companies, age, malpractice suits, and governmental red tape. Health insurance fights the battle of whether it should be provided through public or private based means. Insurance also faces the battle on if insurance should be provided through employees or directly to

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[169] Regina Herzlinger, 2007, *Who Killed Health Care? America's $2 Trillion Medical Problem-and the Consumer- Driven Cure*, "Consumer Driven Benefits: Lessons from Other Countries and Industries," New York, New York: McGraw-Hill, p. 195.

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the individual. The health care system has evolved in these areas over the years but still faces many challenges in deciding its future path.

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