Chapter 1
Primer on the Healthcare System

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Dr. Lane is a new graduate and has entered into the field of hospital medicine. During her limited time as a hospitalist, it has become clear to Dr. Lane that she has a gap in her working knowledge of the healthcare system as a whole. During residency, she focused most of her attention on patient care and less on understanding the system in which she works. She is also starting to realize the impact the current healthcare system has not only on her patients but on herself as a healthcare provider.

Understanding the basics of healthcare and the healthcare systems in which you work is an important aspect of being a successful hospitalist. This chapter will aim to provide a brief overview of the U.S. healthcare system and introduce you to the different aspects of the Affordable Care Act.

The Healthcare System Before the Affordable Care Act

On a basic level, the healthcare in the U.S. prior to the affordable care act was not really a system, but was a mix of public and private insurance as well as "safety nets" for the uninsured that has developed overtime [1]. Private companies in the U.S. covered the vast majority of healthcare costs, accounting for 58.3 % of the population, compared to 26.4 % who had public insurance. The remaining 15.3 % were

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R.J. Habicht and M.S. Gulati (eds.), *Hospital Medicine*,
DOI 10.1007/978-3-319-49092-2_1

uninsured [2]. The uninsured were left to navigate the community health centers, voluntary and public hospitals, and local emergency departments to obtain care.

Private Insurance is comprised of employer-sponsored insurance (ESI) and private non-group insurance. ESI dominated insurance coverage at 53.4 %, compared to 4.9 % that purchased insurance on their own. Under ESI, employers and employees share the cost of the healthcare premiums, with employers paying the majority of the cost. Employers are able to deduct what they pay as an ordinary and necessary business expense and employees are allowed by the federal government to pay for their share of their premium from their pretax salary. This amounts to a tax subsidy for those with ESI. ESI has many advantages. First, any employee of an employer with ESI is eligible for coverage regardless of preexisting conditions. Second, the risks and the costs are spread out among all the individuals in the company, not just the sick. Third, ESI plans are cheaper and more comprehensive than individual plans because of the bargaining power that employers have over insurance companies. The disadvantage to ESI plans is tied to employment. If one loses his/her job, one loses coverage. Also, small employers and the self-employed do not enjoy the benefits of ESI and often went without insurance all together.

Private non-group insurance consists of individuals paying out-of-pocket to private insurers. With these insurance plans, premiums tended to be higher and the risk of insuring the non-group individual was based on the health of the individual, with sicker individuals absorbing higher costs.

Public Insurance

Public insurance is dominated by Medicare and Medicaid, with some smaller programs also providing coverage such as the State Children's Health Insurance Program (S-CHIP) and the Veterans Administration. Medicare, a federal program, insures all individuals aged 65 and over as well as qualifying disabled individuals. Medicare is composed of multiple parts. Part A (hospital insurance) covers inpatient healthcare as well as skilled nursing facilities, hospice and some services like lab tests and surgery. Part B (medical insurance) covers outpatient care, healthcare provider services, home healthcare, durable medical equipment, and some preventive services. Part D is Medicare's prescription drug plan. Medicare, while providing relatively good coverage with remarkable efficiency, has many gaps. Medicare does not cover skilled nursing facilities for all conditions or for an unlimited period of time, does not cover all of preventive care and does not cover dental, hearing or vision care. Because of this, most under Medicare also obtain supplemental insurance [3].

Medicaid is a state run program that covers low-income and disabled individuals. By law, these programs are required to cover low-income pregnant women, children, elderly, and the disabled. In general, Medicaid plans tend to be comprehensive but with lower physician reimbursement rates.

The "Safety Net"

The safety net encompasses the patchwork of "public and voluntary hospitals, community health centers, public health clinics, free clinics, and services donated by private physicians" to provide care of the uninsured [3]. The financing of this safety net varied, from patients paying all costs out of pocket to state and federal appointed funds. This net allowed individuals who did not have insurance to still get medical care when needed; however, uninsured individuals who navigated this net often ended up paying a large amount of their income into providing their own healthcare, often cannot afford preventive medicine screens and relied heavily on the emergency departments of hospitals for urgent care.

The Patient Protection and Affordable Care Act

On March 23, 2010 the Patient Protection and Affordable Care Act (ACA) was officially signed into law. After roughly 50 years of minimal change in healthcare legislation, the largest bill to affect the U.S. healthcare system narrowly passed through the house and senate and became law.

Major Provisions of the ACA

The Individual Mandate

The individual mandate is largely considered to be one of the essential lynchpins of the ACA. Without the mandate, the ACA would be unable to function as intended and would be unable to sustainably expand health insurance access to the millions of Americans that are expected to receive it. Starting on January 1, 2014, the law mandates that American citizens must obtain and maintain "minimum essential coverage" throughout the year. In order for a health insurance plan to count as "minimum essential coverage," it must follow a number of set rules and regulations stipulated by the ACA. There are a large variety of currently available healthcare plans that qualify as meeting minimum essential coverage but the rules can vary depending on the source of insurance. In general, however, for health insurance to be considered minimum essential coverage it must typically include:

1. **Affordability**: Plans cover at least 60 % of out-of-pocket costs for required services
2. **Guaranteed Availability of Coverage**: Individuals cannot be denied coverage for any reason (other than ability to pay)
3. **Guaranteed Renewability of Coverage**: Individuals must be able to renew the policy regardless of health status

4. **Fair Health Insurance Premiums**: Price limits are in place to cap the amount an individual can be charged based on age, tobacco use, family size, and geography
5. **Ten Essential Benefits**: Plans must provide coverage for at least 10 essential health benefits
6. **Dollar Limits**: Insurers cannot place dollar limits on essential benefits
7. **Coverage must provide minimum value**: A plan must cover at least 60 % of the total allowed costs (what the plan pays vs. what the customer pays due to deductibles, copays, and coinsurance)

When an individual is without an insurance plan that counts as a minimum essential coverage and that individual does not qualify for any exemptions, he/she are required to pay a fee (known as the tax penalty or Shared Responsibility Fee) for every month for which there is no coverage. These fees are paid on the individual's federal tax returns for that year and, starting in 2017, the tax penalty will be adjusted according to the rate of inflation or 2.5 % of income (whichever is greater for that individual). While the law requires that most Americans obtain insurance or face a penalty, it does include a number of exemptions which provide a 3 month reprieve from the fee. Some of these exemptions include:

1. **Unaffordable coverage option:** for those who would have to pay >8 % of their household income for health insurance after subsidies
2. **No filing requirement**: For those with incomes that do not exceed the tax filing threshold (in 2014, $10,150—Single person, $20,300—Married filing jointly)
3. **Hardship**: For those that have been certified by the health insurance market place to have suffered a hardship that makes them unable to obtain coverage
4. **Short coverage gap exemption**: For those that go without health insurance coverage for less than 3 consecutive months
5. **Religious conscience:** People who qualify for religious exemptions
6. **Not lawfully present**: People who are undocumented immigrants; Not a U.S. citizen, U.S. national, or is an alien lawfully present in the U.S.
7. **Indian tribes**: Members of federally recognized Indian Tribes
8. **Incarceration**: People who are currently incarcerated

Healthcare Exchanges

Prior to the establishment of the Affordable Care Act, purchasing health insurance for many Americans was a complicated process. Plans tended to have widely differing benefits, so comparing plans directly based on service and price according to each individual's needs often proved challenging. With the decision to include an individual mandate in the ACA, legislators understood that Americans would need

a new marketplace that would allow them to efficiently and effectively purchase health insurance. To meet this need, the law required that every state must maintain a health insurance marketplace, also known as a health exchange, which allows customers to easily compare a number of insurance plans based on rates and benefits. Each exchange not only facilitates the ability of consumers to purchase insurance, but they are also tasked with ensuring that insurers comply with the newly developed consumer protection laws, compete in cost-efficient ways, expand access to coverage to more Americans as well as promote insurance transparency and accountability. There are several different ways that a health insurance market place can be organized in each state [4]:

- ***State-Based Marketplaces***: States are responsible for conducting all marketplace functions. Consumers apply for coverage through these states-specific marketplace website that is established and maintained by that state.
- ***Federally Supported State-Based Marketplace***: States are responsible for performing all marketplace functions, but the state will rely on the federally operated marketplace website. Consumers in these states apply for coverage through healthcare.gov.
- ***State-Partnership Marketplace***: States are responsible for in-person consumer assistance but the Department of Health and Human Services is responsible for performing all other marketplace functions. Consumers in that state apply for coverage through healthcare.gov.
- ***Federally Facilitated Marketplace***: The Department of Health and Human Services is directly responsible for all marketplace functions. Consumers in these states apply for coverage through healthcare.gov. Aside from the ease of being able to purchase insurance through the exchanges, one of the other major draws to encourage use of the health exchanges are government subsidies to purchase insurance. These tax credits are available to those who earn less than 400 % of the federal poverty level and do not have access to employer-based insurance. It is important to note that these tax credits for purchasing insurance are only available to individuals that purchase their plans through the exchanges.

Medicaid Expansion

The ACA has considerable provisions to try to expand Medicaid so that it covers more of the public. The law extends Medicaid coverage to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents and adults without dependent children) with incomes up to 133 % of the Federal Poverty Level [5]. All eligible adults are guaranteed to receive a benefit package that meets the minimum essential requirement of all health plans available through the health exchanges. The decision to expand Medicaid in this manner, however, is at the discretion of each state.

Changes to the Private Insurance Market

The ACA instituted a number of rules to regulate health insurance companies. These changes were mainly put in place to protect consumers and ensure that all Americans received the greatest number of benefits possible for reasonable prices. The most important of these rule changes was the prohibition of individual and family health plans from denying coverage based on preexisting conditions. Along these same lines, insurers became prohibited from placing lifetime and annual limits on the dollar value of coverage. These rule changes ensure that all Americans, regardless of their health status, are able to purchase insurance and keep that insurance even if extensive medical care is required.

The other significant change to the private insurance market is the establishment of a set of preventative services that all marketplace plans must provide to consumers without any additional cost. Many of these services for adults and children include immunizations and screenings that are considered essential to effective primary care. Some of the services that are now assured through the passage of the ACA include blood pressure, cholesterol, depression and autism screening as well as colorectal cancer screening for adults over 50, HIV screening for ages 15–65, breast cancer mammography screening every year for woman over 40, contraceptive coverage, and obesity screening and counseling.

Changes to Employer-Sponsored Insurance

The ACA does very little to change the landscape for employer-provided health insurance. The biggest change that was implemented comes for those who are employed by companies with 50 or more employees and do not have health insurance. These companies will be required to provide health insurance to their employees if they do not have minimal essential coverage already. Companies that do not offer coverage will be assessed a financial fee per employee if they do not offer coverage. Employees are allowed to opt-out of coverage so long as they purchase health insurance in the healthcare exchanges.

Small companies (those with less than 50 employees) are not required to provide health insurance to their employees but are encouraged to do so. The insurance marketplace has a specially designated part, the Small Business Health Options Program, which is specifically designed for small companies to purchase health plans for their employees.

Healthcare Cost and Quality Performance

There are a variety of new programs and policies through the ACA to improve healthcare quality and attempt to contain rising costs. Most of these programs have been implemented through Medicare. One of the more notable programs includes a national Medicare pilot program that will develop and evaluate bundled payments

for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services. Bundled payments are reimbursements paid to healthcare providers that are based on the expected costs for clinically defined episodes of care [6]. If providers are able to supply care for less than the payment, they are able to profit from the savings. If the care given costs more than the payment the provider is then responsible for absorbing the additional costs.

One of the other notable Medicare-based programs is a hospital value-based purchasing program to help pay hospitals based on performance on quality measures. Along with this program, the ACA calls for the development of a national quality improvement strategy that will improve the delivery of healthcare services and patient outcomes in addition to creating a process that will determine quality measures to be used in reporting and payment determination.

Impact on Hospitalists

From the time the ACA was signed into law, there has been speculation over how the legislation would impact physicians, hospitals and other healthcare providers. We have yet to see the full impact that the law will have on providers. As the final provisions of the ACA reach the implementation phase, there are several thoughts as to how physicians, and more specifically hospitalists, will be affected.

One of the prevailing beliefs is that hospitalists will be relied upon more to deliver care. With implementation of pilot programs to facilitate payment changes, hospitalists may have an opportunity to play a bigger role. For example, with the ACA placing penalties on hospitals that readmit patients within 30 days, hospitals are incentivized to optimize patient care on the initial admission. Hospitalists can play a crucial role in making sure that hospitals are able to achieve lower readmission goals as they are more available to care for inpatients and have more expertise caring for hospitalized patients on a day to day basis. Similarly, with bundled payment value-based purchasing pilot programs being developed with the hopes of expanding them nationally, hospitals will likely turn to hospitalists to ensure that cost effective high quality care is provided.

As hospitalists continue to become a more prominent force in the U.S. healthcare system, there are great opportunities to engage those systems at a meaningful level. The first step in doing so, is understanding the systems in which you work and through which your patients receive their care.

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