

Delivering Health Care in America A Systems Approach

S I X T H E D I T I O N

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Production Credits

Executive Publisher: William Brottmiller
Publisher: Michael Brown
Associate Editor: Chloe Falivene
Editorial Assistant: Nicholas Alakel
Production Manager: Tracey McCrea
Senior Marketing Manager: Sophie Fleck Teague

Manufacturing and Inventory Control Supervisor: Amy Bacus
Composition: Cenveo Publisher Services
Cover Design: Kristin E. Parker
Photo Research and Permissions Coordinator: Amy Rathburn
Cover Image: © OrhanCam/Shutterstock, Inc.
Printing and Binding: Edwards Brothers Malloy
Cover Printing: Edwards Brothers Malloy

Library of Congress Cataloging-in-Publication Data

Shi, Leiyu, author.

Delivering health care in America : a systems approach / Leiyu Shi, Douglas A. Singh.—Sixth edition.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-1-284-03775-3 (pbk.)

I. Singh, Douglas A., 1946- author. II. Title.

[DNLM: 1. Delivery of Health Care—United States. 2. Health Policy—United States.

3. Health Services—United States. W 84 AA1]

RA395.A3

362.10973—dc23

2013045774

6048

Printed in the United States of America

18 17 16 15 14 10 9 8 7 6 5 4 3 2 1

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Preface

As of this writing, a few weeks after the health insurance exchanges were opened for enrollment on October 1, 2013, millions of Americans across the nation were beginning to get a first-hand experience with the Affordable Care Act (ACA), nicknamed Obamacare. In a country in which people have been divided almost in the middle on their views, there has been no dearth of speculations on both sides ever since the ACA became law. One side has claimed that the ACA is destined to fail, while the other side has reached the grandiose conclusion that, finally, most Americans will have access to affordable, high-quality health care. We think that such prophetic assertions on both sides are premature. The truth perhaps lies somewhere between the two extremes, but it will not be known for at least a year or two.

Some provisions of the ACA went into effect between 2010 and 2012. They included coverage of children and adults under the age of 26 as dependents under their parents' health insurance plans, elimination of lifetime dollar limits in health plans, increases in annual caps on health care use, inclusion of preventive services with no out-of-pocket expenses, temporary credits to small employers to offset health insurance costs, certain discounts on drugs for Medicare

beneficiaries, and a requirement that health plans spend no less than a certain proportion of the premiums on providing medical care. These mandates, mainly imposed on insurers, were implemented without much ado as most consumers benefited from them. The additional costs were, of course, borne by the insurers. Eventually, however, increased business costs are always passed on to the consumers.

The eventual success or failure of the ACA, or of any other health care reform efforts in the future, will hinge on several factors. Some critical unanswered questions are: Will a large number of young and healthy people enroll through the exchanges to prevent an upward spiral in premium costs, sometimes referred to as a "death spiral?" Will the employment-based health insurance system survive, and, if so, to what extent? Will private insurance companies continue to participate in the government exchanges, or will they hand over the reins to the government at some point? Will the number of providers be sufficient to care for a large influx of the newly insured population? Will Americans have at least the same level of access to health care services that the insured now have, or will access deteriorate for everyone? Will a heavily indebted nation be able to afford the rising levels of

spending without causing serious dislocations in the overall economy? Even though there is uncertainty in these areas, this book attempts to inform the readers on these and many other issues based on what is already known and what some of the trends may be pointing to. In most areas, however, we offer known facts so that the readers can apply their critical thinking skills and draw their own conclusions, pro or con.

Reforms under the new law contain several areas aimed at improving the current health care system. The main areas include a reinvigorated emphasis on prevention; incentives for care coordination; incentives for hospitals to improve quality; enhanced quality reporting requirements; federal assistance to improve the primary care infrastructure, although it is quite inadequate; federal support to authorize “generic” (biosimilar) versions of certain biologics; and insurance coverage for low-income citizens and certain vulnerable groups. These reforms have theoretical bases and precedents so that positive outcomes can be expected in the future.

On the flip side, the ACA has created much confusion, uncertainty, and controversy. For employers, even though the mandate to provide health insurance has been delayed until January 2015, complex reporting requirements will increase business costs. Both large and small businesses are juggling with various options in an effort to find optimum solutions. Eventually, many workers will be left with reduced work hours, unaffordable premiums, without family coverage altogether, or complete loss of a job because of how the ACA has been crafted. As an example of the burden many working Americans are likely to face, researchers at the Kaiser Family Foundation estimated that 3.9 million non-working

dependents were in families in which the worker had employment-based coverage but the family did not. These family members would be excluded from getting federal tax credits to subsidize their purchase of health insurance through the government-run marketplaces. On another front, literally millions of Americans have experienced cancellation of their existing privately-purchased health insurance because the policies do not comply with ACA mandates. That these covered individuals were satisfied with their insurance is inconsequential as far as ACA compliance is concerned. The same individuals are finding premiums to be unaffordable when they sign up for coverage through the government-run marketplaces. A last-minute announcement by the Obama administration on November 14, 2013 to allow existing insurance policies to continue for another year under certain conditions seems to have done little to assuage the problem.

The US Supreme Court did not help matters when it upheld half of the law, but let states decide whether they wished to expand their Medicaid programs—as initially intended by the ACA—or opt out. About half the states have opted out, which leaves many vulnerable groups in those states in a state of uncertainty if they are not already covered under Medicaid.

Other issues associated with the ACA include the bulk of the previously uninsured people still to be left without health insurance (estimated to be around 25 to 30 million), uncertain health care costs, experimentation with untested care delivery models that could create dislocations in access and cost, and controversies and legal actions still in place even after the Supreme Court’s ruling that was handed down in June 2012. The latter category includes lawsuits brought by Catholic and other religious

groups based on objections to providing contraceptives mandated by the ACA. On December 31, 2013, US Supreme Court justice, Sonia Sotomayor, an Obama appointee, issued a temporary injunction that blocked the Obama administration from enforcing the birth control mandate for certain Catholic groups. Of course, the Obama administration has objected to Sotomayor's injunction. According to one report, more than 90 legal challenges have been filed around the country, and the ACA could once again be reviewed by the Supreme Court. In addition, the forthcoming November 2014 congressional elections have some Democrats worried because they voted for the now unpopular ACA. They are trying their best to distance themselves from the ACA. No doubt, the ACA faces turbulent times ahead. Hence, confusion and uncertainty are likely to prevail for some time to come.

New to This Edition

This *Sixth Edition* has undergone some of the most extensive revisions we have ever undertaken. We have done this while maintaining the book's basic structure and layout which, for more than 15 years, has served quite well in helping readers both at home and overseas understand the complexities of the US health care delivery system. Some basic elements of US health insurance and delivery are intentionally retained to assist the growing number of foreign students in US colleges and universities, as well as those residing in foreign countries.

The major updates reflect on two main areas: (1) Regardless of its future, the ACA will radically change health care delivery in the United States, for better or for worse. Because of its far-reaching scope, different

aspects of the ACA are woven through all 14 chapters (see the Topical Reference Guide to the Affordable Care Act for easy reference). The reader will find a gradual unfolding of this complex and cumbersome law so it can be slowly digested. To aid in this process, every chapter ends with a new feature, "ACA Takeaway," as an overview of what the reader would have encountered in the chapter. Details of the law are confined to the context and scope of this book. (2) US health care can no longer remain isolated from globalization. An integrative process in certain domains has been underway for some time. Hence, it has become increasingly important to provide global perspectives, which the readers will encounter in several chapters.

As in the past, this edition has been updated throughout with the latest pertinent data, trends, and research findings available at the time the manuscript was prepared. Copious illustrations in the form of examples, facts, figures, tables, and exhibits continue to make the text come alive. Following is a list of the main additions and revisions:

- Chapter 1:
 - A basic overview of health care reform and the Affordable Care Act (ACA)
 - Critical global health issues
- Chapter 2:
 - Health insurance under the ACA
 - Measurement of *Healthy People 2020* goals
 - Global health indicators
- Chapter 3:
 - E-health and its current applications for consumers
 - New expanded section: Era of Health Care Reform

- Chapter 4:
 - The ACA and physician supply
 - Updated information on non-physician providers
- Chapter 5:
 - Clinical decision support systems (CDSS) and their benefits
 - Introduction to health information organizations (HIOs)
 - Introduction to nanomedicine
 - Revisions to HIPAA in conjunction with the HITECH law
 - Update on remote monitoring technology
 - New section on biologics and their regulation by the FDA
 - The ACA as it applies to medical devices and biologics
- Chapter 6:
 - Adjusted community rating for insurance underwriting under the ACA
 - New exhibit to spotlight differences between the two main types of high-deductible/savings plans
 - New section, “Private Health Insurance Under the ACA,” covering details of the many changes that private insurance plans and employers must comply with
 - Changes in Medicare, including changes in reimbursement, required by the ACA
 - Recent trends affecting the HI and SMI trust funds
 - Ambiguity over Medicaid that creates two different programs and ironies created by the ACA
 - Refined DRGs (MS-DRGs) for reimbursement of acute-care inpatient hospital services, and ACA stipulations for hospital reimbursement
 - Updated current directions and issues in financing
- Chapter 7:
 - Primary Care Assessment Tool
 - Medical home measurement
 - Primary care providers in other countries
 - Current developments in home health care
 - Current developments in community health centers
 - Current developments in alternative medicine
 - Global trends in health care providers
- Chapter 8:
 - New section on hospital utilization and factors that affect hospital employment
 - New section on hospital costs
- Chapter 9:
 - New section on pharmaceutical management as a cost-control mechanism in managed care
 - Introduction to triple-option plans
 - New section on managed care and health insurance exchanges under the ACA
 - Expanded section on accountable care organizations
 - New section on payer-provider integration
- Chapter 10:
 - Limited federal financial incentives to states for additional home- and community-based long-term care services under the ACA
 - New model of continuing care at home
- Chapter 11:
 - The uninsured under the ACA
 - Updated information on the homeless
 - Updated information on mental health
 - Updated information on the chronically ill
 - New section on the migrant populations

- Chapter 12:
 - Current issues in health care cost, access, and quality
 - CMS program related to quality
 - AHRQ quality report card/indicators
 - NCQA and quality measures
- Chapter 13:
 - Current critical policy issues
 - Future health policy issues/challenges in both the US and abroad
- Chapter 14:
 - Expansion of the framework: Forces of Future Change
 - Revised section on the future of health care reform
 - Perspectives on universal coverage and access vs. single-payer system

As in the previous editions, our aim is to continue to meet the needs of both graduate and undergraduate students. We have attempted to make each chapter complete without making it overwhelming for beginners. Instructors, of course, will choose the sections they decide are most appropriate for their courses.

As in the past, we invite comments from our readers. Communications can be directed to either or both authors:

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We appreciate the work of Xiaoyu Nie in providing assistance in the preparation of selected chapters of this book.

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List of Abbreviations/Acronyms

A

AALL—American Association of Labor Legislation
AAMC—Association of American Medical Colleges
AA/PIs—Asian American and Pacific Islanders
AAs—Asian Americans
ACA—Affordable Care Act
ACNM—American College of Nurse-Midwives
ACO—accountable care organization
ACPE—American Council on Pharmaceutical Education
ACS—American College of Surgeons
ADA—American Dental Association
ADA—Americans with Disabilities Act
ADC—adult day care
ADLs—activities of daily living
ADN—associate’s degree nurse
AFC—adult foster care
AFDC—Aid to Families with Dependent Children
AHA—American Hospital Association
AHRQ—Agency for Healthcare Research and Quality
AIANs—American Indians and Alaska Natives
AIDS—acquired immune deficiency syndrome
ALF—assisted living facility

ALOS—average length of stay
AMA—American Medical Association
AMDA—American Medical Directors Association
amfAR—Foundation for AIDS Research
ANA—American Nurses Association
APCs—ambulatory payment classifications
APN—advanced practice nurse
ARRA—American Recovery and Reinvestment Act
ASPR—Assistant Secretary for Preparedness

B

BBA—Balanced Budget Act of 1997
BPCI—bundled payments for care improvement
BPHC—Bureau of Primary Health Care
BSN—baccalaureate degree nurse
BWC—Biological Weapons Convention

C

CAH—critical access hospital
CAM—complementary and alternative medicine
CAT—computerized axial tomography
CBO—Congressional Budget Office
CAAH—continuing care at home
CCIP—Chronic Care Improvement Program
CCRC—continuing care retirement community

CDC—Centers for Disease Control and Prevention
 CDSS—clinical decision support systems
 CEO—chief executive officer
 CEPH—Council on Education for Public Health
 CF—conversion factor
 CHAMPVA—Civilian Health and Medical Program of the Department of Veterans Affairs
 CHC—community health center
 CHIP—Children’s Health Insurance Program
 CIA—Central Intelligence Agency
 CMGs—case-mix groups
 C/MHCs—Community and Migrant Health Centers
 CMS—Centers for Medicare & Medicaid Services
 CNA—certified nursing assistant
 CNM—certified nurse-midwife
 CNSs—clinical nurse specialists
 COBRA—Consolidated Omnibus Budget Reconciliation Act of 1985
 COGME—Council on Graduate Medical Education
 CON—certificate-of-need
 COPC—community-oriented primary care
 COPD—chronic obstructive pulmonary disease
 COTA—certified occupational therapy assistant
 COTH—Council of Teaching Hospitals and Health Systems
 CPI—consumer price index
 CPOE—computerized physician order entry
 CPT—current procedural terminology
 CQI—continuous quality improvement
 CRNA—certified registered nurse anesthetist
 CT—computed tomography
 CVA—cardiovascular accident

D

DC—doctor of chiropractic
 DD—developmentally disabled
 DDS—Doctor of Dental Surgery
 DHHS—Department of Health and Human Services
 DHS—Department of Homeland Security
 DMD—doctor of dental medicine
 DME—durable medical equipment
 DoD—Department of Defense
 DO—doctor of osteopathy
 DPM—doctor of podiatric medicine
 DRA—Deficit Reduction Act of 2005
 DRGs—diagnostic-related groups
 DSM-IV—*Diagnostic and Statistical Manual of Mental Disorders*
 DTP—diphtheria-tetanus-pertussis

E

EBM—evidence-based medicine
 EBRI—Employee Benefit Research Institute
 ECG—electrocardiogram
 ECU—extended care unit
 ED—emergency department
 EHRs—electronic health records
 EMT—emergency medical technician
 EMTALA—Emergency Medical Treatment and Labor Act
 ENP—elderly nutrition program
 EPA—Environmental Protection Agency
 EPO—exclusive provider organization
 ERISA—Employee Retirement Income Security Act
 ESRD—end-stage renal disease

F

FBI—Federal Bureau of Investigation
 FD&C—Federal Food, Drug, and Cosmetic Act
 FDA—Food and Drug Administration
 FMAP—Federal Medical Assistance Percentage

FPL—federal poverty level
 FQHC—Federally Qualified Health Center
 FTE—full-time equivalent
 FY—fiscal year

G

GAO—General Accounting Office
 GATS—General Agreement on Trade in Services
 GDP—gross domestic product
 GP—general practitioner

H

HAART—highly active antiretroviral therapy
 HCBS—home- and community-based services
 HCBW—home- and community-based waiver
 HCH—Health Care for the Homeless
 HDHP—high-deductible health plan
 HEDIS—Health Plan Employer Data and Information Set
 HHRG—home health resource group
 HI—hospital insurance
 HIAA—Health Insurance Association of America
 Hib—*Haemophilus influenzae* B
 HIO—health information organization
 HIPAA—Health Insurance Portability and Accountability Act
 HIT—health information technology
 HITECH—Health Information Technology for Economic and Clinical Health Act
 HIV—human immunodeficiency virus
 HMO—health maintenance organization
 HMO Act—Health Maintenance Organization Act
 HPSAs—health professional shortage areas
 HPV—human papillomavirus
 HRQL—health-related quality of life

HRSA—Health Resources and Services Administration
 HSA—health savings account
 HSAs—health system agencies
 HTA—health technology assessment
 HUD—Department of Housing and Urban Development

I

IADL—instrumental activities of daily living
 ICD-9—International Classification of Diseases, version 9
 ICF—intermediate care facility
 ICF/IID—intermediate care facilities for individuals with intellectual disabilities
 ICF/MR—intermediate care facilities for mentally retarded
 ID—intellectual disability
 IDD—intellectually/developmentally disabled
 IDEA—Individuals with Disabilities Education Act
 IDS—integrated delivery systems
 IDU—injection drug use
 IHR—International Health Regulations
 IHS—Indian Health Service
 IMGs—international medical graduates
 INS—Immigration and Naturalization Service
 IOM—Institute of Medicine
 IPA—independent practice association
 IPAB—Independent Payment Advisory Board
 IRB—Institutional Review Board
 IRF—inpatient rehabilitation facility
 IRMAA—income related monthly adjustment amount
 IRS—Internal Revenue Service
 IS—information systems
 IT—information technology
 IV—intravenous

L

LPN—licensed practical nurse
LTC—long-term care
LTCH—long-term care hospital
LVN—licensed vocational nurse

M

MA—Medicare Advantage
MA-PD—Medicare Advantage
Prescription Drug Plan
MA-SNP—Medicare Advantage Special
Needs Program
MBA—master of business administration
MCOs—managed care organizations
MD—doctor of medicine
MDS—minimum data set
MedPAC—Medicare Payment Advisory
Commission
MEPS—Medical Expenditure Panel
Survey
MFS—Medicare Fee Schedule
MHA—master of health administration
MHS—multihospital system
MHSA—master of health services
administration
MLP—midlevel provider
MLR—medical loss ratio
MMA—Medicare Prescription Drug,
Improvement, and Modernization Act
MMR—measles-mumps-rubella vaccine
MPA—master of public administration/
affairs
MPFS—Medicare Physician Fee Schedule
MPH—master of public health
MR/DD—mentally retarded,
developmentally disabled
MRHFP—Medicare Rural Hospital
Flexibility Program
MRI—magnetic resonance imaging
MSA—metropolitan statistical area
MS-DRGs—Medicare severity diagnosis-
related groups
MSO—management services organization

MUAs—medically underserved areas

N

NAB—National Association of Boards
of Examiners of Long-Term Care
Administrators
NADSA—National Adult Day Services
Association
NAPBC—National Action Plan on Breast
Cancer
NCCAM—National Center for
Complementary and Alternative
Medicine
NCHS—National Center for Health
Statistics
NCQA—National Committee for Quality
Assurance
NF—nursing facility
NGC—National Guideline Clearinghouse
NHC—neighborhood health center
NHE—national health expenditures
NHI—national health insurance
NHS—British National Health Service
NHSC—National Health Service Corps
NIAAA—National Institute of Alcohol
Abuse and Alcoholism
NICE—National Institute for Health and
Clinical Excellence
NIDA—National Institute on Drug Abuse
NIH—National Institutes of Health
NIMH—National Institute of Mental
Health
NP—nurse practitioner
NPC—nonphysician clinician
NPP—nonphysician practitioner
NRA—Nurse Reinvestment Act of 2002
NRP—National Response Plan

O

OAM—Office of Alternative Medicine
OBRA—Omnibus Budget Reconciliation
Act
OD—doctor of optometry

OI—opportunistic infections
 OMB—Office of Management and Budget
 OPPTS—Outpatient Prospective Payment System
 OSHA—Occupational Safety and Health Administration
 OT—occupational therapist
 OWH—Office on Women’s Health

P

P4P—pay-for-performance
 PA—physician assistant
 PACE—Program of All-Inclusive Care for the Elderly
 PAHP—Pandemic and All-Hazards Preparedness Act
 PASRR—Preadmission Screening and Resident Review
 PBMs—pharmacy benefits management companies
 PCCM—primary care case management
 PCGs—primary care groups
 PCIP—Pre-Existing Condition Insurance Plan
 PCM—primary care manager
 PCP—primary care physician
 PDAs—personal digital assistants
 PDP—stand-alone prescription drug plan
 PERS—personal emergency response systems
 PET—positron emission tomography
 PFFS—private fee-for-service
 PharmD—doctor of pharmacy
 PhD—doctor of philosophy
 PHI—personal health information
 PHO—physician–hospital organization
 PhRMA—Pharmaceutical Research and Manufacturers of America
 PHS—public health service
 PMPM—payment per member per month
 POS—point-of-service plan
 PPD—per-patient day rate
 PPM—physician practice management

PPOs—preferred provider organizations
 PPS—prospective payment system
 PROs—peer review organizations
 PSO—provider-sponsored organization
 PSROs—professional standards review organizations
 PsyD—doctor of psychology
 PTA—physical therapy assistant
 PTCA—percutaneous transluminal coronary angioplasty
 PTs—physical therapists

Q

QALY—quality-adjusted life year
 QI—quality indicator
 QIOs—quality improvement organizations

R

R&D—research and development
 RAI—resident assessment instrument
 RBRVS—resource-based relative value scales
 RHIO—Regional Health Information Organization
 RICs—rehabilitation impairment categories
 RN—registered nurse
 RUG-III—Resource Utilization Groups, version 3
 RUGs—resource utilization groups
 RVUs—relative value units
 RWJF—Robert Wood Johnson Foundation

S

SAMHSA—Substance Abuse and Mental Health Services Administration
 SARS—severe acute respiratory syndrome
 SAV—small area variations
 SES—socioeconomic status
 SHI—socialized health insurance
 SHOP—small business health options program
 SMI—supplementary medical insurance

SNF—skilled nursing facility
SPECT—single-photon emission
computed tomography
SSI—Supplemental Security Income
STDs—sexually transmitted diseases

T

TAH—total artificial heart
TANF—Temporary Assistance for Needy
Families
TCU—transitional care unit
TEFRA—Tax Equity and Fiscal
Responsibility Act
TFL—TriCare for Life
TPA—third-party administrator
TQM—total quality management

U

UCR—usual, customary, and reasonable
UR—utilization review

V

VA—Department of Veterans Affairs
VBP—value-based purchasing
VHA—Veterans Health Administration
VISN—Veterans Integrated Service Network
VNA—Visiting Nurses Association

W

WHO—World Health Organization
WIC—Special Supplemental Nutrition
Program for Women, Infants, and
Children

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