

Healthcare in America

An Overview

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Although the healthcare arena is not the only area of practice for therapeutic recreation specialists, it is a principal practice arena. Riley and Connolly (1997) found that among all persons sitting for the certification exam offered by the National Council for Therapeutic Recreation Certification, 78.3% reported health-related settings as their primary service setting. In contrast, only 6.5% of those taking the certification exam listed public parks and recreation, camps, or schools as their primary place of practice. Although health-related settings are not the only practice settings of therapeutic recreation, they are the practice settings of the majority of therapeutic recreation specialists.

Arguably no other aspect of American society has changed more than healthcare during the twentieth century. The nature and structure of healthcare in 1900 bears little resemblance to the nature of care in the year 2000. At the turn of the century, most healthcare was provided by physicians either in their own office or in patients' homes (Ayres, 1996). Yet by the late 1990s, hospital services accounted for one third of all healthcare spending (Dranove & White, 1999). In addition, at the beginning of the twentieth century, payment was made directly to healthcare providers by patients instead of being paid for by a third party. At present, the majority of healthcare services are paid for by such entities as government agencies, private and not-for-profit organizations through a wide variety of payment systems. The purpose of this chapter is to provide a brief overview of the healthcare system in the United States. Particular attention will be paid to examining key themes in public policy that have affected healthcare as well as the present structure of healthcare. Finally, the implications of the healthcare system to therapeutic recreation practice are presented.

Government Involvement in Healthcare Policy

As noted previously, early healthcare involved a direct transaction by the care provider (usually a physician) and a patient. This relationship did not typically involve any other agents such as governments or insurance companies. How is it then that the U.S. federal government is the single largest purchaser of healthcare services (Gapenski, 1993) and healthcare policy occupies such a prominent place in political debates in this country (Marmor & McKissick, 2000)? Mueller (1993) stated that the government's intervention in healthcare is based on the belief that healthcare should be available to all people. Although this basic belief may underlie government involvement in healthcare, Mueller cited two principal variants on the theme.

Two Approaches to Involvement

First, the belief that healthcare should be available to all people can be interpreted to mean that all people have the right to the *same level* of healthcare. Under this variant all members of a society have access to essentially identical services either through (a) the government providing identical health insurance to all citizens (e.g., Canadian model), or (b) through the government making available identical health services to all citizens (e.g., British model). The second variant on the theme underscoring government involvement in healthcare is that all people have a right to a *minimum level* of care. In this approach, the role of government is to ensure that there is a safety net to protect the most vulnerable segments of the population. Through this approach specified members of the society have access to government supported, basic health services (e.g., U.S. model).

Because the United States has adopted this second variant, what one sees in policy are relatively narrowly written pieces of legislation that attempt to fill gaps (Mitchell, Kruger & Moody, 1991; Mueller, 1993). For example, the Social Security Act of 1965, which created both the Medicare (Title XVIII) and Medicaid (Title XIX) programs, was developed in order to provide minimum healthcare coverage for those who either had no access (e.g., retirees) or could not afford (e.g., the poor) private health insurance (Hoffman, Klees & Curtis, 2000; Vorderer, 1997). More recently, the State Child Health Insurance Program (CHIP) was enacted in 1997 to expand public health insurance coverage, through Medicaid, for children in low-income families (Hill, 2000). Again, this policy represents a stopgap measure to ensure that healthcare is available to a single vulnerable segment of the population. As a result of this pattern of piecemeal legislation, some have

argued that it is difficult to characterize healthcare in the United States as a "system" (Mitchell, Kruger & Moody, 1991; Shi & Singh, 2001).

Implications of the U.S. Approach

One implication of the U.S. approach is that all government support need not be available to all people. As noted previously, the U.S. approach has sought to provide health insurance for designated segments of the population. Since most Americans obtain health insurance through employment (Fronstin, 2000), governmental policies have been based on assumptions that citizens who are employed and earning incomes above the poverty level can obtain health insurance privately. A problem with this assumption is that the cost of health insurance continues to rise faster than incomes. The assumption may be in error. Hanson (2001) cited figures that indicated that in 1996, there were 7.7 million families with children who were either without any health insurance (3.2 million) or who only had health insurance for some family members (4.5 million). This figure represents 24% of all families with children in the United States. In addition, by 1998, the estimate was that 44.3 million Americans were without health insurance, and half of these were made up of the working poor (Gemignani, 1999). The *working poor* refers to that segment of the U.S. population who are employed, but earn relatively low incomes. Often times, people in such employment settings earn near minimum wage and often do not have access to employer-sponsored health insurance programs. Gemignani noted that 25% of workers in households earning less than \$25,000 per year have no health insurance.

Another implication of the American approach to government intervention in healthcare raises questions of what are necessary versus elective services. Again, the U.S. approach has been to ensure access to minimum healthcare services. Thus, the political debate has focused on which services are considered to be "medically necessary," and which services are "elective." For example, dentures, dental care, most optical and audiologic services as well as nursing home care are excluded from Medicare coverage (Vladeck, 2001). Given that the debate surrounding the issue of necessary versus elective services has been a largely political debate, it should not be surprising that there is an ever increasing need for therapeutic recreation professionals to be politically astute and assertive (Compton, 1997; Shank, 1997).

Key Themes in Health Policy

In addition to understanding the basis and characteristics of government involvement in healthcare policy in the United States, healthcare policy generally can be examined as having three dominant themes (Mueller, 1993). These three themes have principally revolved around the nature and quality of care, obtaining access to care, and containing the cost of care. Furthermore, these themes have predominated during different periods in the evolution of healthcare in the United States over the past 100 years.

Quality

At the turn of the twentieth century, healthcare was relatively risky business for patients. Care was largely provided in peoples' homes by physicians with little standardized training. Ayers (1996) characterized the practice of medicine from the time of the Revolutionary War to the first decades of the twentieth century as "marked by therapeutic adventurism and just plain foolishness" (p. 11). Although there were approximately 160 medical schools in the United States at the turn of the century (Ayers, 1996), the nature of that education was highly suspect. For example, Beeson (1980) found that only about 6% of the medical interventions found in *Cecil's Textbook of Medicine*, a standard of medical education in 1927, were considered effective interventions in 1980. The condition of medical education was such a growing problem that the fledgling American Medical Association employed Abraham Flexner to survey the state of medical education in the United States. In 1910, Flexner issued *Medical Education in the United States and Canada*, which largely condemned the training of physicians of the time. Among the problems he cited were that there was little medical science included in training, many graduates completed their training in six months or less, there were no entrance requirements (e.g., many students could neither read nor write!), and most faculty maintained a private practice. Largely as a result of Flexner's report, medical education changed to include: (a) a baccalaureate degree as an entrance criterion, (b) inclusion of medical science in training, and (c) the professionalization of clinical faculty.

In addition to changes in the training of physicians, the beginnings of the twentieth century saw increasing involvement of state governments in the regulation of healthcare. Some of the earliest government involvement in healthcare was seen in the certification of healthcare facilities. New York was the first state to enact such legislation in 1894, requiring private facilities to meet certain standards in order to be certified by the State Board of Charities (Mueller, 1993). In addition, there was increasing involvement of government in the credentialing of healthcare providers.

Although only 26 states had enacted licensure laws governing physicians by 1968 (Anderson, 1990), by 1952 twenty health professions were licensed in at least one state (Graddy, 1991).

A third process occurring in the early twentieth century that exemplifies the theme of quality is the changing nature of hospitals. Stevens (1989) characterized this change noting that "between 1870 and 1917 the American hospital was transformed from an asylum for the indigent into a modern scientific institution" (p. 17). During the early decades of the twentieth century hospitals saw such changes as the increasing use of antiseptic procedures, the use of anesthetics, and the employment of professional nurses. All of these forces changed the focus of hospital care to one of rational, scientific services.

Finally, the federal government was involved in the improvement of the quality of care through two important acts. First, in 1930 legislation was passed to create the National Institutes of Health (NIH). The NIH was established with a broad mandate to determine the causes, treatment and cures for diseases (Patel & Rushefsky, 1999). Thus, the U.S. federal government supported the scientific study of medicine through financial support of the NIH. In addition, in 1946 the Hill-Burton Act was passed that provided for federal aid to the states for the construction and expansion of hospitals (Mueller, 1993; Stevens, 1989). The act was largely targeted toward the provision of funds to support hospital services in rural areas and poorer states. Through the Hill-Burton legislation, many areas without any hospital services were now able to construct community hospitals.

Access

In addition to making funds available for the construction of modern hospitals, the Hill-Burton Act can also be interpreted as indicative of access to care (Mueller, 1993). First, this act made hospital care more accessible to people who had previously had little access to modern medicine. Another one of the provisions of the act was that hospitals had to agree to provide a certain amount of "charity care." In other words, to build or expand a hospital under the Hill-Burton funding, the hospital had to agree to provide some care for those too poor to pay for services. The inability to pay for hospital services can also be seen as the impetus for private health insurance in the form of Blue Cross.

Blue Cross began as a hospital insurance plan at Baylor University Hospital in Dallas, Texas in 1929. O'Morrow and Carter (1997) stated that the hospital began to notice that many of its delinquent bills were incurred by teachers at Baylor University. Given that this time frame was

during the Depression, even those who were employed were having difficulty meeting their healthcare costs. Thus, the hospital created an insurance plan, offering 1,500 teachers up to 21 days of hospital care for \$6 per person per month (Starr, 1982). This initial program of insurance was duplicated by other hospitals—first in Dallas and then increasingly across the nation. In addition, similar plans were created to cover the cost of physician services in the hospital. These plans were initially sponsored by state medical societies, but later adopted the name “Blue Shield” (Anderson, 1991). The Depression itself generated concern on the part of hospitals nationwide that patients were increasingly unable to cover their hospital care directly. Costs for care would have to be budgeted in advance through insurance.

Private health insurance also grew during the Second World War (Anderson, 1991). During the war, Congress had enacted controls on wages. As a result, employers were not able to use high wages to attract employees; however, health insurance and pensions were not considered as a part of wages. The result was that employers began to include health insurance as a fringe benefit of employment. By 1952, more than half of the U.S. population was covered by some form of health insurance.

One of the first noted attempts of the U.S. federal government to provide access to care via financial support occurred in 1921 with the Maternity and Infancy Act (PL 67-97). This act was designed provide funding to the states in order for states to develop health services for mothers and children. However, this act was allowed to lapse in 1929 due to opposition from members of Congress and the American Medical Association as “a socialist scheme” (Anderson, 1991). Although notions of national health insurance and widening the access to healthcare were raised during the administration of President Truman in the late 1940s, it was not until the mid-1960s that the federal government became significantly involved in affording access to healthcare. As noted previously, as enrollment in private insurance through employment continued to rise through the 1950s, a growing segment of the population who were not employed could not afford healthcare. With the passage of the Social Security Act Amendments (PL 89-97), the federal government became the primary insurer of the elderly, the poor, and certain segments of the population with long-term illnesses through the creation of Medicare and Medicaid. As a result of these programs, federal and state governments are now the largest purchaser of healthcare services in the United States (Shi & Singh, 2001).

It is interesting to note that access to care in the United States has always been an issue of payment. Unlike countries with more socialized forms of care (e.g., Canada, Great Britain), the U.S. system has historically

been based on a fee-for-service structure. If one could come up with the fee, one could access the service. A story may help to illustrate this issue. In 1992 my wife’s great aunt developed difficulties with her stomach. She was 92 years old at the time and living independently in a large city in eastern Canada. Although she had national insurance (as do all Canadian citizens), she was unable to be seen in a hospital as all the hospital beds were full in the city in which she lived. She instead went to a smaller hospital in a town 75 miles from her home where there were available beds. What’s striking about this case is how it differs from an American example. The idea that a person *with the ability to pay* would be turned away (or have to be assigned to a waiting list) due to lack of available services is highly unlikely in the American healthcare system.

Cost Containment

The third principal theme in healthcare policy in the United States is that of cost containment. The issue of containing the cost of care is a relatively new concern in terms of health policy. However, it is not surprising that it has become such an issue. The cost of healthcare grew dramatically for both individuals and society as a whole in the later half of the twentieth century. As can be seen in Figure 10.1 (page 192), the spending on personal healthcare made up an ever-increasing portion of the gross domestic product from 1960 through the early 1990s.

As healthcare costs continued to rise, a number of initiatives were seen to try to reign in escalating costs. First, the Congress created Professional Standards Review Organizations (PSRO) under the Social Security Amendments in 1972. These organizations were set up to review care for Medicare and Medicaid patients in hospitals, extended care, and skilled nursing facilities (Patel & Rushefsky, 1999). The PSROs had the power to deny approval of payment for services that were deemed unnecessary. Second, with support from the Nixon administration, the Health Maintenance Organization (HMO) Act of 1973 (PL 93-222) was made into law. The purpose of PL 93-222 was to stimulate competition as a means to controlling costs, by encouraging the creation of HMOs as a cost-efficient alternative to traditional care. In addition, in 1974 Congress passed the National Health Planning and Resource Development Act (PL 93-641). The purpose of this act was to prevent unnecessary expansion of the healthcare delivery system (Mueller, 1993). This represented a cost containment strategy because it was felt that the surplus in healthcare services tended to create unnecessary use. Overall, all of the cost containment activities of the early to mid-1970s were

Finally, cost containment approaches could be seen in the private sector in the growth of managed care organizations (MCO). Patel and Rushesky (1999) defined MCOs as organizations offering health insurance plans that seek to restrain the use of health services. This is done through a variety of approaches, but principally this is done through the restriction of choice of service providers. The main impetus for the growth of MCOs appears to be the result of employers, who are one of the largest purchasers of insurance, seeking to contain costs. HMOs, for example, have grown from a nationwide enrollment of 9.1 million in 1980 to 66.8 million in 1997. In other words, by 1997 over 25% of the U.S. population was enrolled in an HMO.

Current Focus

Each of the above themes had its period of dominance. The issue of quality was the predominant theme at the turn of the twentieth century and continued through to almost midcentury. The theme of access, while having its roots in hospital insurance programs during the Great Depression, only achieved predominance in the period following the Second World War and really reached its zenith with the creation of Medicare and Medicaid in 1965. Finally, the period of the mid-1970s until the late 1980s was dominated by efforts at containing healthcare costs. So, what is the current focus of health-care policy? It has been argued that the period beginning with the 1990s has seen a combination of the three themes (Mueller, 1993). Others have argued however that quality has been pushed aside in favor of cost containment and access (McGlynn & Brook, 2001). There may be some validity to this claim as the most recent public policy debates and actions have focused on increased access (e.g., Clinton administration national health insurance, Medicare prescription drug benefits) and cost containment (e.g., Medicare managed care, expansion of PPS into SNFs and rehabilitation settings). The inattention to quality also can be seen in the U.S. ranking in comparison to other countries. The World Health Organization (2000) recently ranked the United States 37th in overall health system performance and 72nd in population health, and at the same time, the United States ranks first among industrialized nations in healthcare expenditures (Shi & Singh, 2001). Thus, current policy does seem to principally involve issues of access and cost containment with little attention on quality.

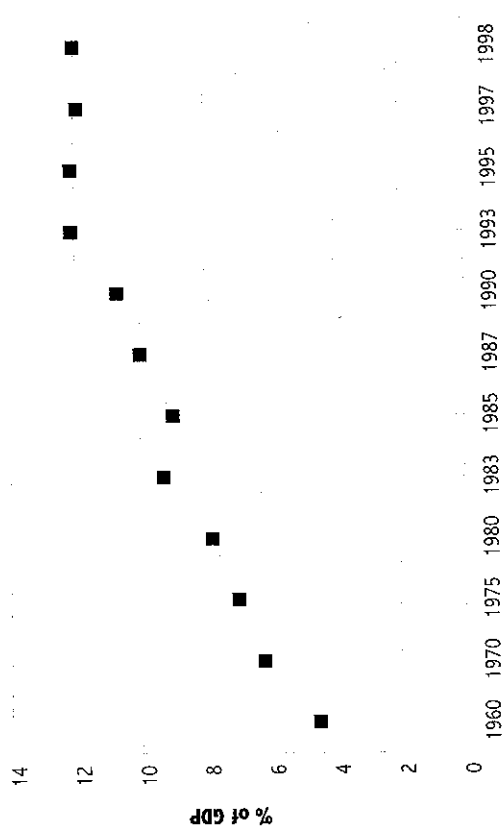


Figure 10.1 Personal Healthcare Expenditures as Percent of U.S. Gross Domestic Product 1960-1998 (Source: U.S. Department of Health and Human Services, 2001)

largely ineffective in containing costs. As a result, the federal government began looking toward more radical departures from past policies.

The more radical departure came in the form of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (PL 97-248) and the Social Security Amendment Act of 1983 (PL 98-21). These two pieces of federal legislation drastically changed the way healthcare was purchased by the U.S. government. The most important changes were that healthcare was no longer paid for based on a fee-for-service structure. Instead healthcare was now to be reimbursed through a prospective payment system (PPS) on a cost-per-case basis (Skalko, 1998), and cases were to be grouped according to diagnosis-related groups (DRGs). What this implied was that the cost of care was no longer set by the healthcare providers' fees. A simplified explanation of the PPS is that a "lump sum" payment is set in advance based on the typical costs associated with treating a particular diagnosis. As a result, the incentive for healthcare providers was to provide cost-efficient care since additional services would not result in additional revenues. Although the initial PPS was implemented only in short-stay inpatient hospitals (Shi & Singh, 2001), it has since been expanded to include skilled nursing facilities (SNFs), post-acute rehabilitation facilities, and will soon include mental/behavioral health facilities.

Structure of Healthcare Delivery

The structure of healthcare delivery is relatively complex with a variety of care providers offering services through a variety of care settings (Nosse, Friberg & Kovacek, 1999; Shi & Singh, 2001). Although therapeutic recreation specialists tend to be employed in greater numbers in some areas of the system than in others, it is useful to understand the structure of the healthcare system.

Care Providers

Care in the U.S. healthcare system is provided by a variety of individuals and organizations. Healthcare providers include those providing preventative care, primary care, and specialty care.

Preventative Care

This type of healthcare provider focuses on the prevention of illness or the enhancement of wellness, including wellness programs, health screening, education programs, and immunization programs. Often times these services are provided through public departments of health, employer-sponsored programs or hospital-affiliated centers. The key characteristic of this form of care is that it occurs *prior* to the onset of illness, injury, or disability. This component of the healthcare system has gained importance as the cost of corrective care has increased (Nosse et al., 1999). Although there seem to be obvious implications for therapeutic recreation services within preventative care (Russoniello, 1997), there is little evidence to indicate that therapeutic recreation specialists are employed in large numbers in preventative care.

Primary Care

Primary care providers are the initial point of contact with the healthcare system for most people following the onset of illness. The main provider of primary care is the general practice physician, although other care providers are increasingly offering primary care. The role of the primary care provider has grown increasingly important as managed healthcare has grown. The role of the primary care provider has expanded from the diagnosis and treatment of illness to that of gatekeeper. Given that specialty care is typically more costly than primary care, the primary care provider role has evolved in such a way that they are now tasked with making determinations about the need for more costly specialized care. Thus they are the gatekeepers for access to specialty care. Although physicians account for the vast majority of primary care, other nonphysician providers such as

nurses, physical therapists and social workers provide primary care (Nosse et al., 1999). In some settings case managers act in this capacity, and it is through the case management role that therapeutic recreation specialists are most likely to provide primary care.

Specialty Care

The most costly and complex services in the healthcare system are those provided by specialty care providers. Specialty care includes those services, equipment and facilities that are not available at the primary level. One of the key distinctions between primary and specialty care is that specialty care typically involves a team approach to care in which the services of a number of specialists must be coordinated. In contrast, primary care typically involves the use of a single care provider. Within specialty care services there are secondary care and tertiary care services.

Secondary care includes such services as routine surgeries, inpatient rehabilitation, pediatric rehabilitation, and diagnostic laboratories. In addition, secondary services also include specialized mental health and substance abuse treatment, as well as geriatric services. Most hospitals constitute this form of care. Tertiary care is the most intensive and specialized (and, hence, costly) form of healthcare provision. They typically serve as regional referral centers, meaning that primary and secondary providers may refer their clients to these centers. Examples of this form of care includes trauma centers, transplant services, cardiac specialty hospitals, and burn care centers. Tertiary care providers typically have the most technologically advanced equipment for diagnosis and treatment of illness and injury. A majority of therapeutic recreation specialists working in healthcare settings are employed in settings that are characteristic of secondary and tertiary specialty care (Riley & Connolly, 1997)

Care Settings

In addition to there being a number of healthcare providers, the U.S. healthcare system involves a variety of settings. Although the beginning of the twentieth century was dominated by healthcare provided by primary care providers to patients in their own homes, at present, home care settings are a minority setting for the provision of healthcare services. In the U.S. healthcare system there are three principal settings for the delivery of healthcare (Nosse et al., 1999).

Ambulatory Settings

These are services provided in a setting that does not keep patients/clients overnight. For example, most care by general practice physicians constitutes

this form of care setting. A person goes to see his or her family physician with symptoms of the flu, is seen by the physician, given a prescription and sent home. However, other forms of care are provided in ambulatory settings. Other examples include urgent and some emergency care, adult daycare, and all outpatient services including diagnostics, surgery, and rehabilitation. Day and partial hospitalization programs that may be seen in mental/behavioral health services are also examples of ambulatory care. Finally, virtually all preventative care is provided through ambulatory settings.

Inpatient Settings

Those receiving services in inpatient settings receive 24-hour care. Further, more inpatient care can be subdivided into acute, postacute, and extended care settings. *Acute care* settings imply that the nature of the illness or disability that caused entry into the setting is relatively serious or severe. In addition, the course of treatment in acute settings is typically the shortest of all inpatient settings. By contrast, *postacute care* settings provide skilled inpatient services, but at a lower intensity or variety of care. Examples of this setting include long-term rehabilitation, surgical recovery centers, brain injury care centers, as well as hospice and respite care (Nosse et al., 1999). The final inpatient setting is that of *extended care*. In the extended care setting, the intensity and variety of services is typically less than even that of postacute care settings. In addition, extended care settings demonstrate the longest length of stay, on average, and discharge is often indefinite. Examples of extended care settings include skilled nursing facilities (SNF), specialized Alzheimer's units, residential services, as well as state hospitals for people with mental illnesses and developmental disabilities. In addition, supported living arrangements, particularly group homes, would constitute this setting of care given that clients are living in a home that is owned and operated by a healthcare provider.

Home Setting

The home care setting is self-explanatory. In this setting, care is provided by a healthcare provider in the home of the care recipient. It has been noted that this is one of the fastest growing care settings (Sensenig, Heffler & Donham, 1997). Examples of home care services include hospice care, patient and family education, as well as wound and disease management.

Healthcare Financing System

The system of financing healthcare services in the United States is highly fragmented. Payment for healthcare services is provided by public entities (i.e., local, state and federal governments), private companies (i.e., not-for-profit, stock and mutual companies) and individual healthcare consumers (see Figure 10.2). Thus the U.S. system is characterized as a *multi-payer*

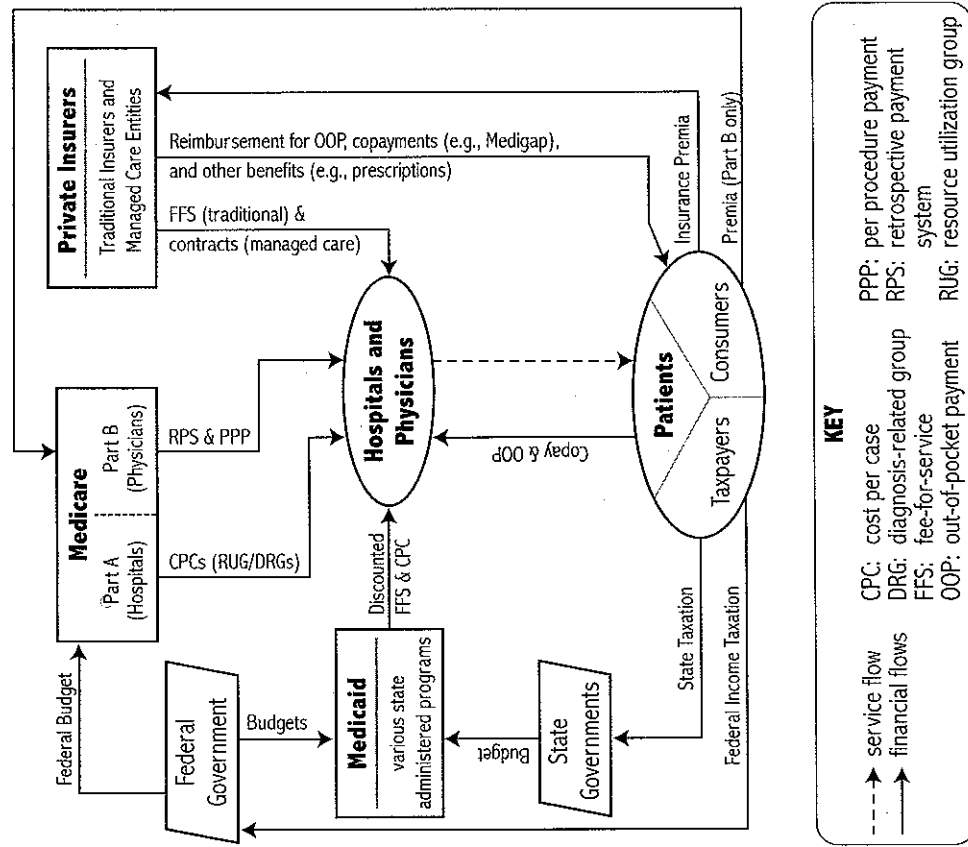


Figure 10.2 U.S. Healthcare System Financial and Service Flows (adapted from McCarthy & Minnis, 1994)

system. This is in contrast to single-payer systems in which the national government is the sole purchaser of healthcare, such as in Canada or the United Kingdom. Explaining the complexity of this system of finance and reimbursement is beyond the scope of this section. Instead, the purpose here is to provide a conceptual overview.

Insurance Basics

In general, American healthcare financing is based on the basic concepts of insurance (Gapenski, 1993). At its heart, insurance is based on ideas of pooling financial costs over a large group in order to make costs more predictable. This can be seen with an example. Suppose the cost of treatment for a broken leg is \$2,500. Based on historical data, an average of ten students a year have an accident resulting in a broken leg at your university. What is the likely amount the student sitting next to you will have to pay for care for a broken leg in the next year? Well, that depends on if he or she experiences an accident resulting in a broken leg (cost = \$2,500) or does not (cost = \$0). The problem is you cannot accurately predict whether or not the injury will happen to *this individual*. However, what is the likely amount the student body will have to pay for care of broken legs? This can be determined by simply using the knowledge of the incidence of the injury (i.e., ten students per year) times the cost of the care (i.e., \$2,500). Thus, you can predict the cost of care for the group, at \$25,000 per year. By pooling costs, the cost of care for a group becomes more predictable.

In addition, insurance prevents an individual in the group from financial catastrophe by *transferring the financial costs* for the individual to the group. Assuming that there are 10,000 students at the university in the above example (and all take part in the insurance plan), the cost of care for all broken legs is \$2.50 per student, per year. As a result, the individual becomes responsible only for that portion of the cost of care spread out over the group. This average cost is the basis for an *insurance premium*. Premiums are the amount an individual pays to an insurer in order to enroll in the program. These are most typically paid monthly and since most people obtain insurance through their employer, they are paid through a payroll deduction.

A final characteristic of insurance is that it is based on costs arising from the *random occurrence* of illness and injury resulting in appropriate care (Gapenski, 1993). If illness and injury occur at random, costs are more predictable within the group. However, some people may seek healthcare services without necessity. For example, lonely people may visit an emergency room out of a need for human contact. The attention and concern

paid by healthcare personnel for socially isolated people may meet a social need, but emergency room services creates costs that are inappropriate to the need. The intentional use of healthcare services and funds without medical necessity is termed *moral hazard*, and insurers have disincentives built into most plans to minimize moral hazards.

Insurers use deductibles and copayments to reduce *moral hazards*. Deductible payments are a fixed amount that the insured must pay out-of-pocket before insurance benefits will cover costs. For example, if a person has a \$250 per year deductible with her health insurance plan, and she receives \$750 in healthcare services, she must pay the first \$250 in costs before her insurer will pay for the remaining \$500. Copayments are also used to minimize moral hazards. *Copayments* are an amount, usually as a percentage, that the insured must pay for the cost of care. A standard copayment is referred to as "80/20," indicating that for all covered care the insured must pay 20% of the costs, while the insurer pays 80%.

Principal Payers

As can be seen in Figure 10.2 (p. 197), there are two payer types for healthcare in the United States. The first and single largest type is public payers (i.e., state and federal governments) who pay for healthcare principally through the Medicare and Medicaid programs. The second payer type represents the multiple private payers. In the U.S. healthcare system there are approximately 1,500 different purchasers of healthcare services (Ayers, 1996), most of them being private companies and organizations.

Public Payers

The principal form of payment for health services by the public is through the Medicare and Medicaid programs. The *Medicare* program provides payment for hospital and physician care to (a) people 65 and older, (b) people with disabilities entitled to social security benefits, and (c) people with end-stage renal disease (Hoffman, Klees & Curtis, 2000). In addition, the program is administered through two parts. Part A provides for hospital insurance, skilled nursing facility (SNF) care, home healthcare and hospice services (Shi & Singh, 2001). For the most part, Part A is free to any U.S. citizen meeting the enrollment criteria, and is financed through social security payroll taxes. Medicare Part B, provides supplemental medical insurance to those enrolled in Part A and is financed through tax revenues as well as premium payments by enrollees. Part B covers physician services as well as outpatient services, emergency department visits, and medical equipment. It is worth noting that Part B also covers outpatient physical

therapy, occupational therapy and speech therapy. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS; known prior to 2001 as the Health Care Finance Administration or HCFA) which is part of the U.S. Department of Health and Human Services.

Medicaid is the other principal public payer for health services. The Medicaid program is designed to provide access to healthcare services through funding healthcare for those who are financially unable to do so for themselves. Unlike Medicare, Medicaid is not a single payer. The reason this one program actually represents multiple payers is that the Medicaid program is set up on a state-by-state basis since the states must provide up to half of the funding for their Medicaid programs (Hoffman et al., 2000). The federal government provides the balance of the cost. Under the legislation, people are eligible for Medicaid if (a) they are receiving support from the Temporary Assistance to Needy Families (TANF) program, (b) they are receiving Supplemental Security Income (SSI), or (c) they are children or pregnant women whose income is at or below 133% of the federal poverty guidelines (Shi & Singh, 2001). In addition, most states have defined additionally eligible people, most notably those in nursing and psychiatric facilities, assuming these individuals have financial assets or incomes that classify them as "indigent" or "poor." Although services do vary by state, they all are mandated to cover hospital and physician costs, nursing facility services, home health, prenatal care, family planning services, medical services to dependent children under age 12, and nurse-midwife services.

Private Payers

A variety of companies make up the mix of private payers. One of the largest private payers is the Blue Cross/Blue Shield system. As noted previously, the origins of this system were in the provision of insurance during the Great Depression. At present, the Blue Cross/Blue Shield system is a group of independent, nonprofit membership corporations insuring hospital, medical and surgical costs for its members in limited geographical areas (Shi & Singh, 2001). Typically the corporations are organized as single or multistate corporations. In addition to the "Blues," private payers also come in the form of commercial insurers including stock and mutual companies (Gapenski, 1993). Stock companies are for-profit entities that provide health insurance in order to make a profit and provide return on investments for stockholders. In contrast, mutual companies are commercial insurers in which policyholders, mainly enrolled through group plans, elect directors to manage the health insurance funds. Although mutual companies are not in business to make a profit, they do work to manage policyholders' funds as efficiently as possible. A final form of private pay is that of the self-insured (Shi &

Singh, 2001). Self-insured does not mean self-pay. In self-pay, the care recipient pays for care directly. A self-insurer is a situation where an employer actually acts as its own insurance company. Gapenski noted that this is only feasible for very large employers, such as the automobile industry or state governments.

Healthcare Reimbursement Methods

Reimbursement methods in the U.S. healthcare system can be based on charges, costs or payments (Gapenski, 1993). Given that there are a very large number of payers in the system, each method may be employed simultaneously at a single healthcare facility since each client may have a different health plan. *Fee-based reimbursement* is one of the simplest forms of payment. This is the typical system of payment for most goods and services outside healthcare. The care provider simply provides to the insurer the "bill" or "fee" for providing services to the insured. This system is also referred to as a *fee-for-service structure*. In some cases large insurers will work out a negotiated fee with the care provider so that they receive a standard discount (e.g., 10%) on all charges. *Cost-based reimbursement* is based on costs incurred by the provider to provide care (Nosse et al., 1999). Typically "allowable costs" are determined by the payer and payers will not provide any payment beyond the cost cap. Nosse and colleagues stated that this form of payment is limited although it continues to play a part in Medicare reimbursement. The third form of reimbursement is set according to *case groups*. Unlike cost-based and charge-based structures, case-based structures are not based on fees or costs but instead based on averaged costs per case. Case groups can be set according to per diem (i.e., a fixed rate per person per day), per admission (i.e., a fixed rate per person per admission), patient characteristics (e.g., diagnosis, resource utilization, functional ability), and capitation (e.g., payment is based on number of plan enrollees). Under capitation, a provider accepts preset dollar amount per plan enrollee in exchange for agreeing to provide specified services to a specified group without any further compensation.

Implications of the U.S. Healthcare System for Therapeutic Recreation

As should be clear from the preceding presentation, healthcare in America is a highly complicated mix of public policy and care providers working through a variety of structures and finances. It is not surprising that as a

profession therapeutic recreation appears to be less than knowledgeable about issues of healthcare structure and finance (Skalko & Malkin, 1992). However, if therapeutic recreation is to remain viable in healthcare settings, it is time we become more astute about the environment in which we practice. Over ten years ago Reitter (1989) warned that:

Disciplines which are most adequately prepared, anticipate changes, and take action in advance to minimize the impact of revisions in financing policy will have the best opportunity to survive in today's highly competitive health care environment. (p. 239)

The statement remains true and can be applied to healthcare policy generally, not just as it relates to finance.

Discussion Questions

1. Consider the two approaches to government involvement in healthcare. What are the advantages to the "same level of care for all?" disadvantages? What are the advantages of the "minimum level of care for all?" disadvantages?
2. Identify a recent piece of state or federal healthcare legislation. Which of the three themes does it most clearly represent: quality, access, or cost containment?
3. Think about a time when you received healthcare services. What type of provider did you see? What was the setting of care?
4. Do a search of newspaper and magazine articles about Medicare or Medicaid. What is the tone of the article? Does the article favor expansion or restriction of the program? Does it discuss costs? the uninsured? the underinsured? the quality of care?