

-U.S. Health Coverage Status- Connecting to and Engaging Associated Reimbursement and Disability Issues/ Events

Presented to Regional Liaisons by Ed Gdula

Senior Consultant, Advocacy

2010

ed.gdula@gbp-cidp.org



Comments on

- Global Healthcare Models
- Healthcare Situation in the United States
- Healthcare Issues affecting Reimbursement-what can be done about it
- Healthcare Issues affecting Disability-what can be done about it

Special acknowledgement to veteran *Washington Post* foreign
correspondent T.R. Reid

NPR Correspondent
Washington Post's Rocky Mountain Bureau Chief
Health Policy Fellow of the Kaiser Family Foundation

In *Sick Around the World*, FRONTLINE teams up with
veteran *Washington Post* foreign correspondent [T.R. Reid](#) to
find out how [five other capitalist democracies](#) -- the United
Kingdom, Japan, Germany, Taiwan and Switzerland --
deliver health care, and [what the United States might learn](#)
from their successes and their failures

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>

There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting *the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.*



But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems.....

The Beveridge Model

- Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library.
- Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.
- Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style health care, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control.

The Bismarck Model

- Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction.
- Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model -- Germany has about 240 different funds -- tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides.
- The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.

The National Health Insurance Model

- This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.
- The single payer tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated.
- The classic NHI system is found in Canada, but some newly industrialized countries -- Taiwan and South Korea, for example -- have also adopted the NHI model.

The Out-of-Pocket Model

- Only the developed, industrialized countries -- perhaps 40 of the world's 200 countries -- have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die.
- In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease.
- In the poor world, patients can sometimes scratch together enough money to pay a doctor bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care.

cont.....

The Out-of-Pocket Model

- These four models should be fairly easy for Americans to understand because we have elements of all of them in our fragmented national health care apparatus. When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany.
- For the approximately 16 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.
- The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody. This is much simpler than the U.S. system; it's fairer and cheaper, too.

Burkina Faso ?

Burkina Faso (formerly Upper Volta) is a landlocked country located in the middle of West Africa's "hump." It is geographically in the Sahel--the agricultural region between the Sahara Desert and the coastal rain forests. Burkina Faso achieved independence from France in 1960. Repeated military coups during the 1970s and 1980s were followed by multiparty elections in the early 1990s. Burkina Faso's high population density and limited natural resources result in poor economic prospects for the majority of its citizens. Recent unrest in Cote d'Ivoire and northern Ghana has hindered the ability of several hundred thousand seasonal Burkinabe farm workers to find employment in neighboring countries.

Population 14 mil+

Explain the Separate U.S. Systems

Traditional Health Insurance (also known as Fee-For- Service Plans)

- Generally, the most flexible type of health plan
- Patients can choose any doctor or specialist without getting approval first
- Type of payment used by some health insurers that pays providers for each service after it has been delivered
- Deductibles and co-insurance apply
- Patient and the insurer pay for part of the costs for the health care services received

Explain the Separate U.S. System

Health Maintenance Organization (HMO)

- A health insurer that contracts with or employs a network of doctors, hospitals and other types of providers
- Patients must visit a provider within the HMO network
- Some require a primary care physician to coordinate care and need a referral from a primary care physician before seeing an in-network specialist, entering a hospital or receiving some types of non-emergency care
- Co-payments required for provider visits

Explain the Separate U.S. System

Preferred Provider Organization (PPO)

- A health plan with a network of providers whose services are available to enrollees at lower cost than the services of non-network providers. PPO enrollees may self-refer to any network provider at any time without a referral.
- Similar to an HMO plan except you do not have to choose a physician to coordinate your care
- Patients can see any provider they choose but higher co-insurance can apply if the provider chosen is not a provider within the network

Explain the Separate U.S. System

Point of Service Plans (POS)

- A health plan in which enrollees select providers either within or outside of a preferred network, with co-payment or deductibles higher for out-of-network providers.
- Similar to an HMO plan but patients can also see providers not in the network and pay a percentage of the charge after the deductible is met.
- A referral is needed for in-network specialists, and no referral needed for out-of-network specialists but co-payments or coinsurance are required
- Restrictions may apply to the services patients receive outside the network

Explain the Separate U.S. System

Exclusive Provider Organizations (EPO)

- Similar to HMOs but patients generally are not reimbursed for care from providers not in the network, except in emergency situations.
- Require a primary care physician to coordinate care and need a referral from a primary care physician before seeing an in-network specialist, entering a hospital or receiving some types of non-emergency care.

Explain the Separate U.S. System

High-Deductible Health Plans (HDHP)

- A health plan with a minimum deductible of \$1,050 for individual coverage and \$2,100 for family coverage. The maximum in-network out-of-pocket limits for allowed costs must be no more than \$5,000 for individual coverage and no more than \$10,000 for family coverage.
- Enrollee pays higher deductibles compared to other types of health insurance coverage
- Services may be delivered through PPO, HMO or POS plans.
- HDHP are partnered with a [Health Savings Account](#) (in PDF) (HSA) or a [Health Reimbursement Arrangement](#) (in PDF) (HRA) that allows you to make tax-deductible contributions for future medical expenses.
- Ineligible for HSA if enrolled in any other health insurance plan, Medicare, or are receiving Veteran's benefits. HRAs are available with an HDHP for those not eligible for an HSA.

Explain the Separate U.S. System

MEDICARE

- Medicare is an insurance program. Medical bills are paid from trust funds which those covered have paid into. It serves people over 65 primarily, whatever their income; and serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program. It is basically the same everywhere in the United States and is run by the Centers for Medicare & Medicaid Services, an agency of the federal government.

www.medicare.gov.

Explain the Separate U.S. System

MEDICAID

- Medicaid is an assistance program. Medical bills are paid from federal, state and local tax funds. It serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses. A small co-payment is sometimes required. Medicaid is a federal-state program. Eligibility varies from state to state based on the financial health of the state. It is run by state and local governments within federal guidelines.

<http://www.cms.hhs.gov/home/medicaid.asp>

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

The 2009 Poverty Guidelines for the 48 Contiguous States

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add \$3,740 for each additional person.

Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2008

<http://www.statehealthfacts.org/comparemapdetail.jsp?ind=205&yr=63&typ=2&cha=253>

Look how eligibility changes from one state to the next !

New Mexico

FPL @ 409%

Louisiana

FPL @ 20%

Fees and Costs

- **Premiums:** A premium is a fee you pay the insurer during a specified period in order to receive health insurance benefits.
- **Deductible:** Some plans require you to pay a set amount each year, called the deductible, before the plan starts paying. Deductibles are common in traditional coverage and PPOs.
- **Coinsurance:** Some plans make you pay a percentage of the cost of services, usually 20-30 percent. For example, you pay 20 percent of the cost, and your insurance pays 80 percent of the cost. Your portion is the coinsurance.
- **Co-payment:** Some plans require you to pay a flat fee for medical services or prescription drugs. For example, you pay a \$10 co-payment for a doctor visit or a \$50 co-payment for a hospital stay.
- **Maximum out-of-pocket:** Some plans limit the total amount of money you will have to pay in the event of major health problems called the maximum out-of-pocket expense.
- **Lifetime maximum:** Some plans may limit the total amount of benefits it will pay, often referred to as a lifetime maximum.

U.S. Health Insurance Coverage

- U.S. has approximately 300 million people
- 47 million people do not have Health Insurance even though nearly 70% of the uninsured have at least one full time worker in the family and another 12% have only part-time workers. 9 million are uninsured children
- 25 million people have been tagged as underinsured.

Information provided by the [Kaiser Commission on Medicaid and the Uninsured](#)

Publication Number: 1420-10

Publish Date: 2008-09-16

WHY ARE SO MANY AMERICANS UNINSURED?

Most Americans obtain health insurance through their employers; however, job-based coverage has declined in recent years. The percentage of firms offering coverage dropped from 69% in 2000 to 60% in 2007, which was in part due to rising premiums.

In 2007, the annual employer group premium for a family of four was \$12,106, nearly double what it was in 2000.

Information provided by the [Kaiser Commission on Medicaid and the Uninsured](#)
Publication Number: 1420-10
Publish Date: 2008-09-16

Average Annual Premiums for Single and Family Coverage, 1999-2008

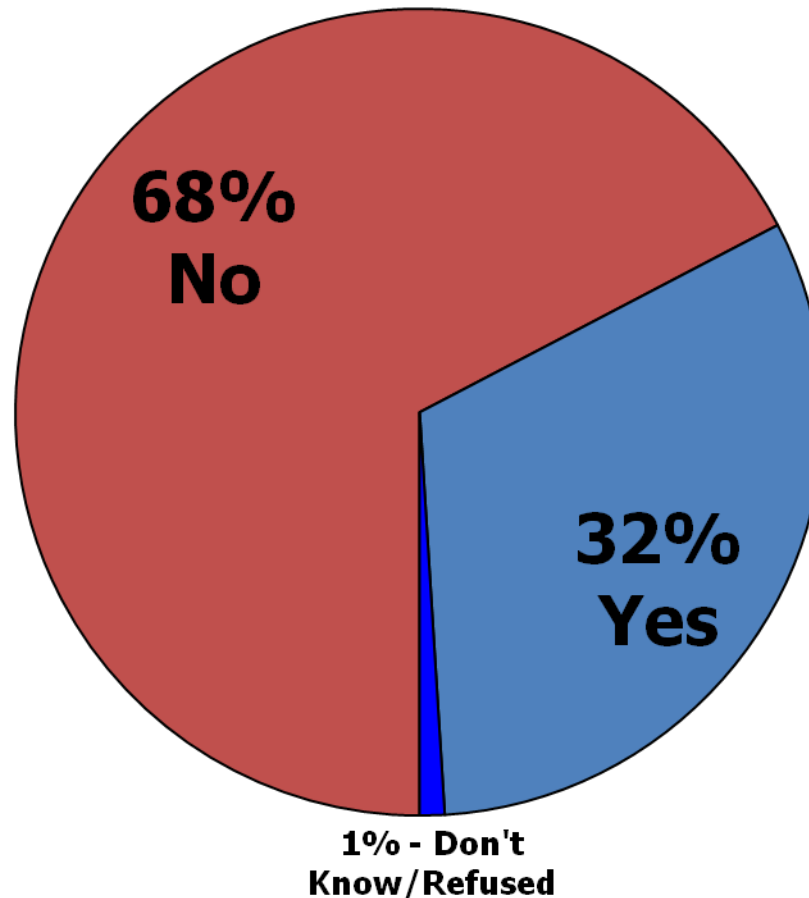


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.

Problems Paying Medical Bills, October 2008

In the past 12 months, did you or another family member in your household have any problems paying medical bills, or not?



FILING A CLAIM FOR YOUR HEALTH OR DISABILITY BENEFITS



Reviewing The Summary Plan Description

- A key document related to your plan is the summary plan description (SPD). The SPD provides a detailed overview of the plan – how it works, what benefits it provides, and how to file a claim for benefits
- Before you apply for health or **disability benefits**, review the SPD to make sure you meet the plan's requirements and understand the procedures for filing a claim.



Filing A Claim

- Check your plan's benefits and claims procedure before filing a claim. Read your SPD and contact your plan administrator if you have questions.
- Once your claim is filed, the maximum allowable waiting period for a decision varies by the type of claim, ranging from 72 hours to 45 days. However, your plan can extend certain time periods but must notify you before doing so. Usually, you will receive a decision within this timeframe.
- If your claim is denied, you must receive a written notice, including specific information about why your claim was denied and how to file an appeal.

cont.....

Filing a Claim

- You have at least 180 days to request a full and fair review of your denied claim. Use your plan's appeals procedure and be aware that you may need to gather and submit new evidence or information to help the plan in reviewing the claim.
- Reviewing your appeal can take between 72 hours and 60 days depending on the type of claim. The law and the Department's rules allow a disability plan additional time if the plan's administrator has notified you beforehand of the need for an extension. For an appeal of a health claim, the plan needs *your permission* for an extension. The plan must send you a written notice, telling you whether the appeal was granted or denied.



cont.....



Filing a Claim



- If the appeal is denied, the written notice must tell you the reason it was denied, describe any additional appeal levels or voluntary appeal procedures offered by the plan, and contain a statement regarding your rights to seek judicial review of the plan's decision.
- You may decide to seek legal advice if your claim's appeal is denied or if the plan failed to establish or follow reasonable claims procedures. If you believe the plan failed to follow ERISA's requirements, you also may want to contact the nearest EBSA office concerning your rights under ERISA.

Resources

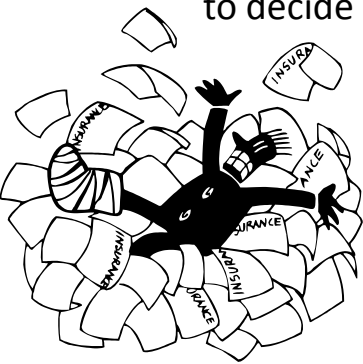
For the EBSA regional office nearest you or a copy of any EBSA publications, call toll free: 1.866.444.EBSA (3272), or visit EBSA's Web site at: www.dol.gov/ebsa

Types Of Claims

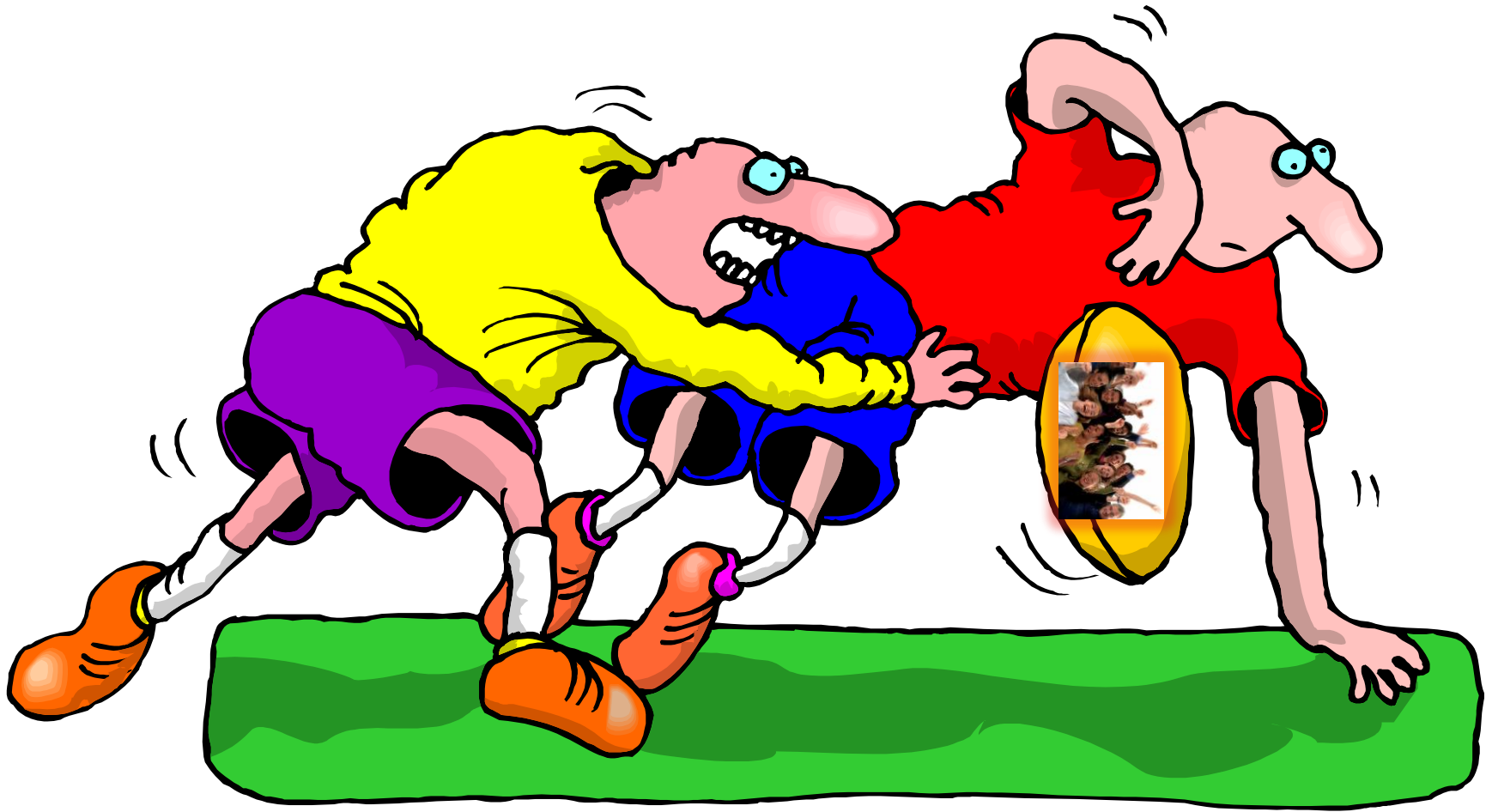
All health and disability benefit claims must be decided within a specific time limit, depending on the type of claim filed.

Group health claims are divided into three types: *urgent care*, *pre-service* and *post-service claims*, with the type of claim determining how quickly a decision must be made. The plan must decide what type of claim it is except when a physician determines that the urgent care is needed.

- ***Urgent care claims*** are a special kind of pre-service claim that requires a quicker decision because your health would be threatened if the plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your medical condition tells the plan that a pre-service claim is urgent, the plan must treat it as an urgent care claim.
- ***Pre-service claims*** are requests for approval that the plan requires you to obtain before you get medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.
- ***Post-service claims*** are all other claims for benefits under your group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided. Most claims for group health benefits are post-service claims.
- **Disability claims** are requests for benefits where the plan must make a determination of disability to decide the claim.



A Consumers Guide to Handling Health Plan Disputes



A most Important Guide

<http://www.kff.org/consumerguide/7350.cfm>

This Guide was prepared by Trudy Lieberman, Director, Center for Consumer Health Choices, Consumers Union; Elizabeth Peppe, Consultant to the Center for Consumer Health Choices; and Janet Lundy and Gary Claxton of the Kaiser Family Foundation.

[The Kaiser Family Foundation](#) is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

[Consumers Union](#) is an independent, nonprofit testing and information-gathering organization, serving only the consumer. It is a comprehensive source of unbiased advice about products and services, personal finance, health nutrition, and other consumer concerns. Since 1936, Consumers Union's mission has been to test products, inform the public, and protect consumers.

A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan, 2005 Update", (#7350) The Henry J. Kaiser Family Foundation and Consumers Union, August 2005

A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan

Section 1 -- Know Your Coverage

- Understand What Type of Coverage You Have & What Laws Apply
- Understand What Services Are Covered
- Understand Your Plan's Rules
- Checklist For Diagnosing Your Coverage

Section 2 -- Appealing To Your Health Plan

- **Preparing an Informal Appeal**
- **Preparing a Formal Appeal**
- **Health Plan Review**
- **Arbitration**

Section 3 -- Getting An Independent Opinion -- **External Review in Your State**

- **Who Can Appeal**
- **What Types of Problems You Can Appeal**
- **When You Can Appeal**
- **How To Appeal**

Kaiser Family Foundation

www.kff.org

- **Kaisernetwork.org:** <http://www.kaisernetwork.org>
- **KaiserEDU.org:** <http://www.KaiserEDU.org>
- **StateHealthFacts.org:** <http://www.statehealthfacts.org>
- **GlobalHealthReporting.org:** <http://www.GlobalHealthReporting.org>
- **GlobalHealthFacts.org:** <http://www.GlobalHealthFacts.org>
([see more options](#))
- **Health08.org:** <http://www.health08.org>

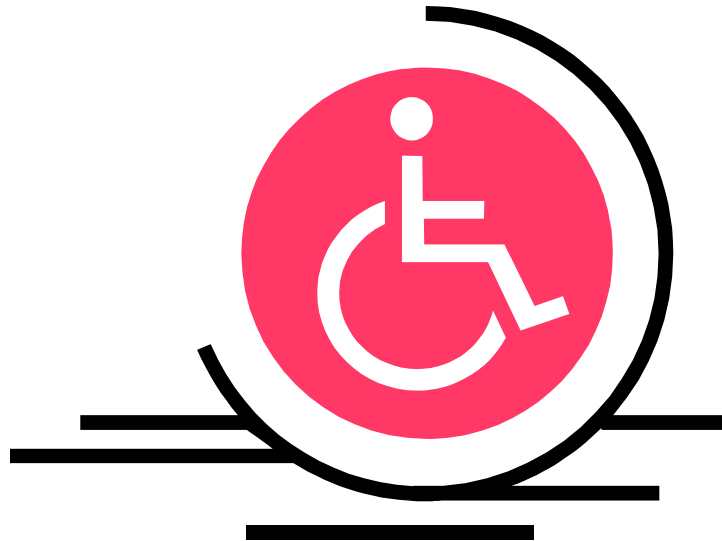
You are welcome to link to the homepage or any other page(s) on the Kaiser Family Foundation Websites. Please note that you may link to any of the Kaiser Family Foundation websites without permission or charge.

Disability Issues

<http://www.disabilityinfo.gov/digov-public/public/DisplayPage.do?parentFolderId=219>

<http://www.eeoc.gov/policy/docs/902cm.html>

What's on this website?



DisabilityInfo.gov

<http://www.disabilityinfo.gov/digov-public/public/DisplayPage.do?parentFolderId=166>

DisabilityInfo.gov provides quick and easy access to comprehensive information about disability programs, services, laws and benefits. You can begin your search by visiting any of the nine subject areas at the top of this page. To find disability resources in your state just click on the *Find State and Local Resources* map located in each of these subject areas.

Some of the many topics you will find information about on **DisabilityInfo.gov** include:

- [Americans with Disabilities Act \(ADA\)](#)
- [Fair Housing Rights](#)
- [Social Security Disability Benefits](#)
- [Vocational Rehabilitation](#)



The Employee Retirement Income Security Act of 1974 (ERISA)

www.dol.gov

- Employees participating in retirement and health benefit plans are granted several important rights by the [Employee Retirement Income Security Act \(ERISA\)](#). Among them are the right to: disclosure of important [plan information](#), a timely and fair process for benefit claims, elect to temporarily [continue group health coverage](#) after losing coverage, a certificate evidencing health coverage under a plan, and recover benefits due under the plan.
- It is important for employees and their families to know their benefit rights to make their benefits work for them.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210
1-866-4-USA-DOL

WHAT IS DISABILITY?

- The Social Security Administration test of disability is **"An inability to perform any substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months."** (1) In Social Security terms, "substantial gainful activity" means work that "(a) involves doing significant and productive physical or mental duties; and (b) is done (or intended) for pay or profit."
- A person is ineligible to receive Social Security disability benefits if he or she:
 - Is working (except in a "sheltered" setting), even though chronically ill
 - At present has the statutory ability and capacity to work
 - Recovered within 12 months of the onset of a disabling illness
 - Has no medically determinable impairment (except for one of the somatoform disorders, which are considered under a separate set of rules) .

Disability Issues

<http://www.disabilityinfo.gov/digov-public/public/DisplayPage.do?parentFolderId=500>

ADA Amendments Act of 2008

- On Thursday, **September 25, 2008**, President George W. Bush signed into law S.3406, the Americans with Disabilities Act (ADA) Amendments Act of 2008. This new law clarifies and broadens the definition of disability, and expands the population eligible for protections under the Americans with Disabilities Act of 1990. For more information about the law visit ADA.gov.

What to expect when filing for benefits

Just when you feel your worst you are asked to fill out reams of paperwork and gather documents from your medical team to back up your claims and proof of your income.

- You turn in your paperwork, you endure the agony of a face to face interview and are told you will hear from them soon.
- Weeks, perhaps months go by as you wait for a reply. Money is tight and you are at the end of your rope by the time you finally get a letter from the government. Ripping open the envelope you expect to see a well deserved check, instead you find a form letter informing you that your claim has been denied. The government doctors have deemed that you are not disabled according to the current laws.

Now you have to make a decision, appeal or let it go.

What to expect when filing for benefits

- Between 60% and 75% of all first time applicants will be denied benefits.
- You have sixty days to file an appeal, do it!
- Statistics show that over 50% of applicants are awarded benefits after filing an appeal
- If the appeal fails, the next step is a hearing before an Administrative law judge. He must hear your argument. Over 50% of people win their benefits at this stage.

It would be very wise to have an experienced SSI lawyer at your side during the hearing



Importance of Caregivers

<http://www.ncsl.org/programs/health/forum/caregiversupport.htm>

National Conference of State Legislatures

444 North Capitol Street, N.W., Suite 515

Washington, D.C. 20001

(202) 624-5400

www.ncsl.org

Pennsylvania -Family Caregiver Support Facts at a Glance

Facts in Brief	Pennsylvania	United States
Population age 60+	2,430,820	45,797,200
Population age 65+	1,919,200	34,991,800
Population age 85+	237,600	4,239,600
 <u>Adult with Disabilities</u>		
Age 21 to 64 with a disability	17.5%	19.2%
Age 65+ with a disability	39.4%	41.9%
 <u>Informal Caregiving</u>		
# of informal caregivers in the state	1.2 million	27.2 million
Caregiving hours per year	1.3 billion	29 billion
Market value of informal care	11.6 billion	257 billion

Good Luck with all your efforts !

The two galaxies happen to be oriented so that they appear to mark the number 10. The left-most galaxy, or the "one" in this image, is relatively undisturbed apart from a smooth ring of starlight. It appears nearly on edge to our line of sight. The right-most galaxy, resembling a zero, exhibits a clumpy, blue ring of intense star formation. The galaxy pair was photographed on October 27-28, 2008. Arp 147 lies in the constellation Cetus, and it is more than 400 million light-years away from Earth. Makes us feel awfully small, doesn't it ?!

Interacting Galaxies Arp 147

Hubble Space Telescope • WFPC2

