

Pacific University

## CommonKnowledge

---

College of Optometry

Theses, Dissertations and Capstone Projects

---

5-21-1995

### Money, money, money.....! How will health care reform affect your practice?

Susan Horeak  
*Pacific University*

Lisa Kollis  
*Pacific University*

#### Recommended Citation

Horeak, Susan and Kollis, Lisa, "Money, money, money.....! How will health care reform affect your practice?" (1995). *College of Optometry*. 1140.  
<https://commons.pacificu.edu/opt/1140>

This Thesis is brought to you for free and open access by the Theses, Dissertations and Capstone Projects at CommonKnowledge. It has been accepted for inclusion in College of Optometry by an authorized administrator of CommonKnowledge. For more information, please contact [CommonKnowledge@pacificu.edu](mailto:CommonKnowledge@pacificu.edu).

---

## Money, money, money.....! How will health care reform affect your practice?

### Abstract

National health care reform is a subject on everyone's minds. Today, our purpose is to examine health care and why the United States is so focused on a reform system. We look at the history of health care and how it's changed and been shaped in past. Through various endeavors, either the private sector or government has been able to avoid the issue. Definitions are given to guide the reader to understanding confusing terms and then an investigation into current Medicare and Medicaid models is explored. The role of business and public opinion is a real concern to this issue; as shown by the American people. Many have looked to Canada for solutions, but seeing their semi-successful system does not seem to provide an answer. Finally, a look at the options for U.S. health care reform and managed care is addressed. Optometry has a place. The future promises the inclusion of the profession in reform but nothing is certain. So the question is still unanswered, what happens now?

### Degree Type

Thesis

### Degree Name

Master of Science in Vision Science

### Committee Chair

Leland Carr

### Subject Categories

Optometry

## Copyright and terms of use

If you have downloaded this document directly from the web or from CommonKnowledge, see the "Rights" section on the previous page for the terms of use.

**If you have received this document through an interlibrary loan/document delivery service, the following terms of use apply:**

Copyright in this work is held by the author(s). You may download or print any portion of this document for personal use only, or for any use that is allowed by fair use (Title 17, §107 U.S.C.). Except for personal or fair use, you or your borrowing library may not reproduce, remix, republish, post, transmit, or distribute this document, or any portion thereof, without the permission of the copyright owner. [Note: If this document is licensed under a Creative Commons license (see "Rights" on the previous page) which allows broader usage rights, your use is governed by the terms of that license.]

Inquiries regarding further use of these materials should be addressed to: CommonKnowledge Rights, Pacific University Library, 2043 College Way, Forest Grove, OR 97116, (503) 352-7209. Email inquiries may be directed to: [copyright@pacificu.edu](mailto:copyright@pacificu.edu)

**MONEY, MONEY, MONEY.....!**  
**HOW WILL HEALTH CARE REFORM**  
**AFFECT YOUR PRACTICE?**

*BY*

*SUSAN HOREAK*

*&*

*LISA KOLLIS*

A thesis submitted to the faculty of the  
College of Optometry  
Pacific University  
Forest Grove, Oregon  
for the degree of  
Doctor of Optometry  
May 21, 1995

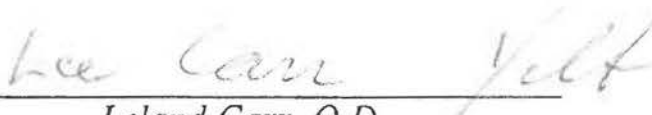
ADVISOR:

*LELAND CARR, O.D.*

SIGNATURE PAGE:

  
\_\_\_\_\_  
Lisa Kollis

  
\_\_\_\_\_  
Susan Horeak

  
\_\_\_\_\_  
Leland Carr, O.D.

## BIOGRAPHICAL PAGE:

### *Susan Horeak*

I received my Bachelor of Science in Biology in 1990 for the University of Regina, Saskatchewan, Canada. I was on the Dean's List for two years and received a proficiency scholarship in my final year. I then attended Pacific University and completed a four year Doctor of Optometry Degree. My future plans are to return to Regina where I will join my father who is also an optometrist already in private practice.

### *Lisa Kollis*

Hi, my name is Lisa and I was born and raised in Northern Iowa and Southwestern Iowa. I received my high school diploma with honors from Sioux Falls Christian High School and then went on to attend Dordt College in Sioux Center, IA with a merit scholarship. From Dordt I received my Bachelor of Arts Degree with a major in Biology. Then a venture to the Northwest was in order to engross in studies for a Doctorate in Optometry anticipated on May 21, 1995. My future is as everyone's, uncertain. However, the immediate involves going up to Alaska to begin practicing with a private practitioner this August. My time here at Pacific has certainly been memorable. Many times I will not soon forget.



## **ABSTRACT:**

National health care reform is a subject on everyone's minds. Today, our purpose is to examine health care and why the United States is so focused on a reform system. We look at the history of health care and how it's changed and been shaped in the past. Through various endeavors, either the private sector or government has been able to avoid the issue. Definitions are given to guide the reader to understanding confusing terms and then an investigation into current Medicare and Medicaid models is explored. The role of business and public opinion is a real concern to this issue; as shown by the American people. Many have looked to Canada for solutions, but seeing their semi-successful system does not seem to provide an answer. Finally, a look at the options for U.S. health care reform and managed care is addressed. Optometry has a place. The future promises the inclusion of the profession in reform but nothing is certain. So the question is still unanswered, what happens now?

## ACKNOWLEDGEMENTS:

Thanks must be attributed to Dr. Leland Carr for his extreme patience and understanding with this project. He remained calm and reassuring during this stressful time. Thanks must also be given to Alden N. Haffner, O.D., Ph.D., profession of optometry at SUNY for his insight as to where to start this project. Gratitude is also given to BSK for their allowed funding, most of which in the end was not needed.



## INTRODUCTION:

This paper is a literature review of health care reform as we see it now in Spring of 1995. We look into the past history of proposed ideas to institute a national health care system for the United States. These have most obviously not been very successful but have accomplished the task of satisfying both the public and business communities for certain periods of time. Medicare has been looked at as a guide by which to know what to do or what not to do. It has worked only to a limited extent and not fulfilled the promises its developers had anticipated.

Many options have been proposed for health care reform. These include the single-payer approach, the play-or-pay system, the Heritage Foundation tax credit plan, and the managed competition proposal (already being instituted to a certain extent by the private sector). Managed competition actually incorporates general concepts ranging from Health Maintenance Organizations (HMOs) to traditional private indemnity plans. All of these ideas seek to control costs while giving the consumer acceptable levels of care.

The Canadian health care system has been looked at with envy by some Americans, but do the Canadians really have a social health care system that works? Some say yes, others say the high taxation and governmental regulation are not worth what the system provides.

Finally, how will health care reform affect optometry? This remains unclear as no plan has come close to gaining consensus support. Any universally endorsed plan would probably include reimbursement for optometric services. But does optometry want to accept lower compensation and a larger patient load or should we resist health plan membership and remain

independent, functioning on a fee-for-service basis? Our future is one hanging in the rafters of Congress. We will probably be included in health reform – but the outcome is unknown. Then again, what would our future be if we couldn't help in shaping it?

## **PURPOSE:**

One of the big reasons the health care crisis is so hard to resolve is that it is hard to focus attention on something so vast, so decentralized, and so hard to summarize. The purpose of reform should be to focus the attention, primarily of taxpayers and premium payers, on their common interest in controlling spending. The business community must be directly involved, and education of corporate lenders becomes essential.

It is a great mystery that business can spend so much on health care yet know so little about how the health care system really operates and what must be done to fix it.

## **Definitions**

*Accountable Health Plan (AHP)* An AHP is a health plan that 1) offers only the uniform set of effective benefits, 2) enters into agreements with a sufficient number and variety of providers to provide those benefits, and 3) has established grievance procedures. An AHP could be an HMO, PPOs or indemnity plan.

*All-Payer System:* A key feature of an all-payer system is that all or the majority of payers of health care benefits are required to pay the same rate for a given health care service (thus the term "all-payer"). This approach prevents providers from shifting costs among third-party payers. Several states, e.g., Maryland, Massachusetts, New Jersey and New York, have or had

all-payer systems for hospital inpatient services. One key feature of each of these programs was the imposition of some sort of rate-setting approach.

*Employer Mandates:* Under this approach, employers would be required (“mandated”) to pay a certain amount for the purchase of health insurance for their employees. One variant of the employer mandate is called “play-or-pay”.

*Exclusive Provider Organization (EPO):* A type of PPO where the patient must “exclusively” use the providers within the PPO. This characteristic is sometimes called a *lock-in provision*. If the EPO entity bears risk that is directly related to utilization of its enrollees; it can be categorized as a *Risk-sharing EPO*.

*Gatekeeper:* A primary care physician (i.e., a family practitioner, internist, or pediatrician) who is responsible for coordinating *all* services. In a gatekeeper plan, most elective specialist or hospital care cannot be delivered without the gatekeeper’s approval. This system is used by most HMOs and EPOs. In HMOs, the gatekeeper is usually placed at financial risk for referral and hospital care, a condition that serves as a disincentive to “open the gate.” In non-HMOs, the gatekeeper does not share risk and is paid separately for gatekeeper services. State Medicaid programs use this approach fairly extensively and often label gatekeeper physicians as *case managers*. There have been some instances of physicians forming networks to offer their coordinating services to integrated delivery systems that choose to purchase them. Such freestanding groups of gatekeepers have sometimes been called *primary care networks*.

*Global Budgets:* This approach would establish overall limits on health care spending, both public and private. Expenditures exceeding these overall limits would then trigger penalties. In general, a global limit is often accomplished by requiring states to establish health care provider fee schedules that would be applicable to all third-party payers. The budget could be established based upon national, regional or local health spending levels.

*Health Care Financing Administration (HCFA):* HCFA was an organization created in 1977 to oversee the Medicare program, the federal portion of the Medicaid program, and related quality assurance activities. They regulate finances and costs for providers, consumers, and insurers.

*Health Insurance Purchasing Cooperatives (HIPCs):* HIPCs could be considered "farmers' markets" where farmers come to sell their goods and consumers come to buy. HIPCs would enter into agreements with AHPs. Individuals in a geographic area would enroll in an AHP through the designated HIPC. The HIPC would collect the enrolled individuals' premiums and forward them to the appropriate AHP. The enrollment period, distribution of comparative information, and the period of coverage would be specified. The HIPC would be required to distribute information to eligible individuals and employers. The information would be designed to permit comparison of the various AHPs on the basis of prices, outcomes, enrollees' satisfaction, and other information pertaining to the quality of different AHPs.

*Health Maintenance Organizations (HMOs):* HMOs offer prepaid comprehensive coverage for hospital, physician, and other health care services. Members must use one of the participating health care providers with whom the HMO contracts in order to receive covered health care benefits. There are several types of HMOs.

A group model HMO consists of a single multi-specialty medical group. This medical group is the primary provider of physician services to the HMO members. HMO members must utilize these physicians for all covered services, unless referred to an outside physician. Generally, the physicians are partners or stockholders in the medical group which has a contract with the HMO.

A staff model HMO has mostly salaried physicians that only serve HMO members. The staff model HMO also may have a small number of physicians, e.g., specialists, that render care on a fee-for-service basis.

An individual practice association/independent physician association ("IPA") is a plan comprised of independent physicians practicing individually or in a single specialty group. The IPA markets the physicians' services to an HMO. The IPA physicians serve the HMO members as well as patients not enrolled in the HMO. The HMO may either contract with the IPA directly or it may contract with the physicians on an individual basis.

A single benefit organization ("SBO") offers only one type of health care benefit or service in the managed care setting. SBOs that are state qualified generally offer vision and dental benefits, or workers' compensation and mental health benefits.

*Managed Care:* A term often used generically for all types of integrated delivery systems, such as HMOs and PPOs, implying that they "manage" the care received by consumers (in contrast to traditional fee-for-service care, which is "unmanaged"). More recently, the terms often used to denote the entire range of utilization control tools that are applied to manage the practices of physicians and others, regardless of the setting in which they practice. In addition to being used in all HMOs, PPOs, and EPOs, these controls that are increasingly being applied to conventional fee-for-service indemnity plans. The types of methods used to manage the patient's care may include preadmission certification, mandatory second opinion before surgery, certification of treatment plans for discretionary non emergency services (such as mental health care). Primary care physician gatekeepers and nonphysician case managers to monitor the care of particular patients. The actual managing organization is frequently an entity separate from the payer or insurer. Among managed indemnity plans, this type of organization is often called a *managed care company* or *third-party administrator*.

*Managed Competition:* In general, managed competition is a system in which health plans compete with other plans on equal footing. Large HIPCs would be established. These HIPCs would enter into agreements with AHPs. Each AHP would be required to offer the same set of benefits established by a national board. In order to become an AHP offered by the HIPC, the AHP would have to offer those standard benefits, comply with insurance reforms, disclose information on medical outcomes, cost-effectiveness, and consumer satisfaction. As a result,

providers and payers would be forced to form some sort of partnership. Each AHP would have to compete for enrollment based on price and quality.

*Medicaid:* Medicaid is a health-care program funded jointly by U.S. federal and state agencies. It provides medical payments for those whose monthly income falls below state-specified levels, and who are 65 or older, blind, disabled, or members of families receiving AFDC-Aid to Families with Dependent Children. If covered by both Medicare and Medicaid, Medicaid will usually cover expenses not paid by Medicare.

*Medicare:* Medicare is a system of U.S. government-provided health insurance for the elderly. Operated by the Social Security Administration, it is designed for persons 65 years old and older, and for the severely disabled. Medicare helps to pay for services of physicians, inpatient hospital care, some outpatient hospital services, and limited home care after the patient leaves the hospital.

Medicare Part A, which helps pay hospital costs, covers all enrollees. Part B, Supplementary Medical Insurance, is an optional plan for which a premium is charged. It pays 80 percent of the fee for each office visit to a doctor, and recently increased payments for preventative medicine and lowered payments for surgery and specialty services.

*Preferred Provider Organizations (PPOs):* A PPO is a health care benefit arrangement between a panel of providers and a purchaser of care. It is designed to provide benefits at a reasonable cost by providing its members with incentives to use preferred providers. The panel of "preferred providers" agrees to a specified fee schedule in return for the preferred status and must comply with certain utilization review guidelines. The members of a PPO can use either preferred or non-preferred providers. Typically, members are given financial incentives to use preferred providers by reduced out-of-pocket liability.

There are various types of PPOs. In an open system, PPO members may choose to use a preferred provider on a service-by-service basis. In a lock-in system, PPO members select once during a specified period to use only preferred providers.

*Rate-Setting:* There are three basic rate-setting models: 1) the budget limit, 2) charge-based controls, and 3) pricing controls. Under the budget limit model, regulators approve each hospital's total budget. Hospitals are penalized if their revenues/expenditures exceed the set budget limit. In the charge-based model, regulators approve charges or rates for specific hospital services. These charges or rates could be established such as on a per diem basis, per ancillary services basis, or some other basis. Finally, in the pricing model, regulators establish a price per episode of service, such as an admission or discharge. The Medicare prospective payment system is an example of the pricing model.

*Single-Benefit Plan:* An entity that subcontracts with other organization, e.g., HMOs, indemnity insurers, or EPOs (usually on a capitated basis), to provide health services only within a "single benefit" category. Single benefit plans have been set up to provide mental health, dental, or eye care only. The providers in these plans may or may not participate in risk-sharing arrangements, but the plan itself usually is at full risk for the services it contracts to provide. These plans are often termed *carve-out plans*, because selected services are carved-out of the full array of coverage offered by the main insurer.

*Utilization Review:* Utilization review is the process of assessing the medical appropriateness of a suggested course of treatment for a particular patient. The most common form of UR is pre-admission certification, that is, the process by which a physician or patient must request prior approval for a non-emergency inpatient admission. This process also is referred to as "utilization management". "UROs" are entities that approve UR/UM services for other interested parties such as self-insured plans, indemnity or other third-party payers. Typically, UROs attempt to help these parties control costs.

## HISTORICAL:

For eighty years, national health insurance has been on (and then off) the American Political menu. The concept has evolved into different things at different times. Each reform effort created a new set of political conditions to shape the next generation of proposals.

For example, the medical profession and its allies successfully resisted government control over health care for years. Costs seemed to rise to a degree, as a result. Then, both public and private sectors responded with an inventory of apparently makeshift cost control devices: stricter controls over reimbursement, new organizations to oversee health care providers, and elaborate research designed to uncover ineffective medical treatments. These things add up to a significant invasion into the body of the medical profession.

There are some issues historians return to so often that they become relics in the field, to be examined and explored, over and over again. No inquiry better qualifies for this label than the question of why the United States never enacted a national health insurance program. Why is it the only industrialized country (exception being South Africa) that has not enacted such a basic social welfare policy?

### Middle Class Removed

First, a look to the 1930's. It was during this era that the concept of "entitlement" became part of American culture. The Roosevelt Era first established the notion that being a citizen of the United States guaranteed a certain minimal level of basic well-being; and that it was the federal government's role to ensure this occurred. As a result of the Great



Depression, American social welfare legislation was transformed, as shown by passage of the Social Security Act. Also, at this time, the faith in the efficacy of medical interventions was firmly established and the consequences of a denial of medical care, obvious. Back in the 1910's, some possible reformers designated the role of health insurance not as compensation to the sick for wages lost during illness, but as an opportunity to receive curative medical care. Twenty years following, this idea was still religiously followed, although the efficacy of medical interventions was, at least compared to today, less than respectable. The 1930's also showed the rise of the hospital to that status of it being a temple of science with its leaders. Men in White, greatly awed.

So, to wonder why reform did not come about at this time is a mystery. Was it FDR's reluctance to go against the AMA (American Medical Association)? Perhaps it was the conscious removal of the middle class from the coalition of advocates for change. This would, in effect, deflate the political pressure for national health insurance.

One of the essential groups in designing and putting into actions this strategy was a new private health insurance company, Blue Cross. Blue Cross was able to present itself as the best alternative to government involvement. Through advertisements, pamphlets, radio programs, and publications; Blue Cross insisted neither rich nor poor would have difficulties obtaining medical services. The rich could afford it, and poor had ready access to public hospitals. Only the middle classes faced a problem, and therefore were forced to move for a change in government policy regarding health care. It was said by a Blue Cross official, "The average man, with average income had pride. He is not looking for charity; he is not looking for ward care. He wants the best of attention for himself and his family... Yet, out of his savings, he is very seldom prepared to meet unexpected sickness or accident expenses."

Therefore, to use the public hospital not only provided the second-best care, but to be looked at as dependent. The alternative was a private subscription plan, which ("for as little as 3 cents a day"-Blue Cross slogan) protected its enrollees from the high costs of health care/hospitalization. All of this led to the conclusion that private enterprise was voluntarily providing hospital care that was within reach of everyone and therefore solving the public health problem in a democratic way.

Blue Cross was successful in its enrollment. It took time, but by 1939 there were 39 Blue Cross plans in operation with more than 6 million subscribers. As time went on, so did Blue Cross growth with 31 million subscribers by 1949. The public's belief in his policy resulted in the opinion that there was no reason to press for political change when the private sector seemed to have resolved the issue. Now that the middle class was out no longer in pushing for reform, politics could be business as usual. Healthcare reform was no longer a major agenda item.

Blue Cross then gained strength in the post-1945 period from the labor movement. Union leaders negotiated contracts that provided unionized workers with health care benefits, further decreasing the need for government programs. As a result, public responsibility for health care became that of a welfare system's: serving only the poor, not the respectable. Coverage through the government became known as something to be provided for "them", and was not necessarily for all U.S. citizens.

### Physician = Entrepreneur

Another critical element in failing to bring about national health insurance was the character/attitude of the medical profession. Historians found diversity in medical opinion on national health insurance in the Progressive

Eras, but by the 1920's, most physicians were very unsettled with government intrusions and supported their fee-for-service system.

Financial self-interest was a force in shaping doctors attitudes, but not the only one involved. In the 1930's the medical profession was not a lucrative one. The thought that a payment from Washington D.C. was better than none from the patient, should have been an enticing one. But this was not the case. The mind-set of most physicians remained one of independent proprietorship. They were businessmen, and therefore shared a mutual aversion for government intervention.

This entrepreneurial perspective thrived and doctors were readily accepted as part of the local business elite. Medical schools perpetuated this concept in classes consisting almost exclusively of white, upper-middle class males. An image is constructed of the usual Wednesday afternoon off, doctor chatting with town banker, lawyer, and CEO's about investment opportunities and politics, with a joint antagonism for the "evil of government control".

Physicians were able to voice their opinions through the lobbying efforts of the AMA, as well as through individual efforts. They were known in their towns as being an "ultimate" authority. Their opinions were heard, and they were respected by most of the community. All of these situations collimated the entrepreneurial style of the American physician.

### Medicare's Effects

Surprisingly, Medicare's enactment reinforced views that health care, elderly excluded, was completely sound and well. The argument began that elderly citizens didn't have the income to pay for private insurance plans and that they were also the group most likely to need health care services. This

statement automatically excluded those under 65 as not needing as much from any health care system. It also implied that in general, these younger individuals had employer-provided or privately underwritten insurance to cover them in the unusual event that they were to require health services. This fueled the middle-class exclusion.

Many predicted that Medicare would become the first step towards national health insurance. Unfortunately, the proponents were too strong in their case for the elderly. Medicare was designed to protect the elderly middle class from burdening health care costs. It was not intended to break new ground by changing welfare policies or by reevaluating health care rights. Thus, it shouldn't be surprising that for the next several decades, Medicare didn't inspire any overall changes in the national health care system.

## CURRENT MEDICARE AND MEDICAID MODELS:

Looking at Medicare and Medicaid systems as they are requires excessive analyzation as to why these systems do not fulfill the intentions they were designed for. Medicaid is a system intended to provide the poor with reliable access to medical care. Medicare, as described earlier, is a system intended to provide both hospital and physician-based medical care for the elderly.

Some have suggested extending Medicaid benefits to all those under the poverty level, and to standardize program benefits. This expansion would require each state to increase its fiscal efforts significantly. Many states claim they simply don't have the resources needed. Besides financial problems, extreme differences exist between Medicaid and existing private plans in terms of benefits, cost sharing, cost containment, and provider payment. If

escalated to a national system, these differences could limit program economics, and would certainly cause problems with patient perceptions regarding equity and continuity of care, and effects on migration.

## **Accountability Under the Medicare Model**

### *Background*

Medicare carriers are private contractors that manage Medicare Part B claims (those not related to a hospitalization) for the government. Typically they do this as well as provide private health insurance for businesses and individuals. An example would be Blue Cross-Blue Shield in the State of Oklahoma. Thus, Medicare carriers reimburse Medicare providers and they also evaluate physician's practices and Medicare recipients' utilization patterns. The latter is reported to and regulated by HCFA (Health Care Financing Administration).

### *Carriers' Medical Review Programs*

Carriers' medical review programs evaluate the use of a program by providers as well as recipients of service. It involves the study of utilization and centers on a review of claims submissions. A review program is basically the process of reviewing claims submitted for reimbursement. There are two types of review: prepayment and post-payment.

A prepayment review is just like it sounds. Particular claims are selected and reviewed before payment is given. This type of review is automated, where the carriers develop treatment parameters and design computer programs (screens) to single out claims that don't fit within these parameters. That flag automatically pulls the claim for manual review. Authorization of payment is only given after review of diagnoses, copies of medical records, etc. Problems arise when the carriers intert on catching fraud, or medically

unnecessary procedures/claims disregard the motive/reason for the testing/procedure. As long as the question of motive remains unasked, both carriers and HCFA(Health Care Financing Administration) may assume that providers use services inappropriately, and that unnecessary care and provider abuse goes on. This obviously creates an adversarial relationship between providers and carriers. Adding to the problem is the belief by providers that people lacking medical training make these decisions on procedures and tests. This is in part true, and reinforced the fact that the people behind the computer (insurance reviewers and adjusters) hold the real power in determination of claim reimbursement.

Postpayment Review differs from prepayment in two basic ways. First, instead of looking at a specific claim, it reviews a physician's practice pattern over a certain time period. Thus, numerous claims are reviewed collectively. Second, and most obviously, it reviews claims after the authorization for payment has been made.

Postpayment looks at physicians whose policies and practices differ from the norm and those who overutilize certain procedures. A provider is picked for review when aggregate cost and utilization figures stand out as "different" from standard cost and utilization figures for other providers in that region.

Differences between a pre- and postpayment review is essentially that prepayment is service-specific, whereas postpayment review is provider-specific. Note how far these reviews move from concerns about medical appropriateness and clinical guidelines. In a never-ending circle, providers are selected for review based on an arbitrarily defined threshold supposedly showing a "significant" departure from the norm; prepayment review is then based on the postpayment results of "abuse".

The questions may be asked: "How will published Clinical Guidelines ever be used in determining medical necessity? Will standard levels of care ever directly determine or influence reimbursement of services? "

## **THE BUSINESS COMMUNITY AS AN INSTRUMENT OF CHANGE:**

Corporate America may be the essential ingredient for any "recipe for health care reform". If big business were to unite behind a plan, the momentum would be hard to resist. A strong business consensus could threaten the traditional dominance of providers and insurers. Getting businessmen to define their interest as consistent with the collective goals of controlled costs and wider access would allow a political chance for change. The question remains as to whether or not the business community can be mobilized to offset the established status quo.

Three major constraints face business in trying to unite in a health reform crusade. First, businessmen are ideologically predisposed to distrust the government. A national plan that increased federal control over health-related financial decisions will automatically meet with skepticism. Second, even though business collectively has reason to want to control costs, individual interests vary. Large, unionized, companies now subsidize uninsured costs, many who work at minimum-wage jobs without benefits. Third, corporate executives have the choice to join the political struggle for cost containment or may choose for a short-term, individualized solutions, an example being cost shifting, which does little to stop the overall problem of the health care burden.

It seems likely that for health care reform to occur, a core group of corporate reformers must organize. Some part of the business community must decide

that health care reform is a top political issue and that increased government direction is necessary and appropriate. This may be an unlikely scenario. Following this, at the legislative stage, business must become organized to support a given proposal and to lend resources and energy to the legislative battle. Still, recruiting business to overcome provider intransigence does not necessarily forecast a successful outcome. If the business community does choose to become involved in a collective reform effort, the many details, specifics, exclusions, and transition rules of legislation will be influenced by "politics as usual". Various groups will lobby to influence the final shape any reform package takes on. Self-interests will still affect the outcome.

As stated earlier, the new system is expected to include optometry. The optometrists are likely to see more patients and accept lower reimbursements. There will also be more utilization reviews because the emphasis of the new system will be focusing on preventative primary care, keeping costs down as much as possible. Optometrists are indeed in a good position to provide that care and still keep costs low.

## **ROLE OF PUBLIC OPINION:**

The American people seem to favor the concept of major change in health care delivery and coverage. Exactly how badly they want to change, and into what direction they wish to go, remains unclear. The interesting thing is that while favoring health care reform, there is an uneasiness about increasing government involvement. This ambivalence of public opinion reform and government involvement has a varying impact on policy and deliberations.

It may be the source of America's inability to increase access to care while administratively controlling the cost. It is the public's desire for better health care, but fear of government involvement, that prompted law makers to



increase government's financial contributions to health care while allowing budgetary decisions to be made by private insurers.

### *Funding*

Many Americans support the financing of health care through new taxes, particularly added taxes on liquor and cigarette sales, and on insurance premiums paid by employers and health providers. Others favor funding health care through reallocation of funds from areas like the military. The question remains tantamount; how do we pay for any new plan we endorse? How can limited resources be extended to allow universal access? To this point in time, no one has proposed a plan that the country is clearly able to afford, and this makes many would-be reformers reluctant.

But how important is public opinion on policy deliberations? This depends a lot on how strongly and persistently the opinions are voiced. Public opinion is influential when it is unambiguous and consistently strong. In this case, the opinion of the public is strong but unsettled toward reform and simultaneous significant government involvement. In spite of this, it is likely, that opinion will influence whatever evolves. The public's real concern over health care concurs with the high priority government policy makers place upon it.

President Clinton is very sensitive to the people's uneasiness about the government running things. This means the single-payer system like Canada is not being pushed. This, along with virtual bankruptcy within the Canadian system, virtually assures this will not become the model here. Because there is significant support for universalism, reform advocates can use this to build slow and incremental acceptance for the necessary but unwelcomed government role in capping the health budget. As to what extent government will really play is yet to be seen.

## A CANADIAN COMPARISON:

Currently, Canada does not include optometry in its *national* health insurance plan. It has been the individual provinces financial responsibility to insure optometric services. This has been a very costly process for many years; as people would go for their perceived "free" eye examination too frequently. By 1985, provinces decided to put a restriction on how many times a person could visit the optometrist for a covered eye exam. Those between the ages of 18-64 could have one complete eye exam every two years. Those outside that, annually. Only if there was a valid reason (e.g., a change in prescription enough to lower visual acuity significantly, or specific referral from a physician, etc.), could someone be seen more than once in that time frame. With that still costing too much, some provinces are deinsuring optometry altogether starting with Saskatchewan in 1990. This basically returns optometry to a fee-for-service profession in that province. Only children under age 18 are covered in Saskatchewan and then only once a year. The reimbursements are now around \$39.00 per patient. The problem, as stated earlier, is simply that the government can't afford to pay for people getting routine eye exams when very often they have no problems. The same situation is happening in the chiropractic profession as well. Preventive care appears to be an idea that simply isn't affordable under a system subsidizing care for the masses.

In spite of all the high taxes, low reimbursements, and now deinsurance, many Canadian optometrists still prefer their Canadian health care system over the system in the United States. The reason is, perhaps, the security that Canada offers of knowing there's unconditional access to some level of guaranteed, "free" health care. However, the problem comes when people

realize it isn't really free. Talk to any American and many are horrified by the taxes Canadians have to pay. Many Canadian optometrists would like to see optometric services covered by the Federal Health Act while others (albeit mostly established) are very happy with deinsurance. With deinsurance, patients are paying up to \$90.00 an exam and most come in with a specific need or problem. Some optometrists feel more job satisfaction with this system. They prefer to have a patient pay them for a service when they have solved a specific problem, as opposed to patients coming in for a so called "free" exam and not really needing service. On the other hand, many optometrists feel their practices are slowing down, and they are afraid of going broke. Some argue that with deinsurance, an optometrist can charge more and see fewer patients. With optometric services insured, the doctor will have to see more patients and they to accept lower reimbursements. Because many of these patients will present for a routine exams, fewer glasses and/or contact lenses will be sold.

If there is to be a national health plan, it is important that optometry be included and that it maintain some level of parity with medicine. Otherwise, the profession could be in trouble. In Saskatchewan and Alberta, optometric services performed by ophthalmologists are also deinsured. This results in many ophthalmologists referring patients back to optometrists to obtain their glasses or contact lenses. Prior to 1985, Alberta deinsured optometry but not ophthalmology; so everyone went to ophthalmology for their eye exams. The end result was that it ended up costing the provincial government more as medical reimbursements were significantly higher. The co-management that exists today with optometry and ophthalmology works nicely for some, as the Canadian ophthalmologist has no interest in refractions and eyeglasses and does not have a dispensary in his/her office. This is not the case in the U.S. where many ophthalmologists welcome patients seeking eyeglasses or contact lenses and often maintain dispensaries. 19

## Prospects for a Canadian-Style Reform

Whatever virtues the Canadian health care system may have, such a model probably will not work in the U.S.. Physician and hospital sectors would have to submit to the additional government controls. This is something that the body of medicine would likely fight against.

The Canadian system is often criticized for the fact that during periods of growth, financing is generous, yet it is restricted at times when government needs to tighten spending. Fearing such cost containment tactics, the American Medical Association would probably protest any single-payer, governmental control. Because the insurance body is so strong in the U.S., the single-payer system is a sure fail.

## OPTIONS FOR U.S. HEALTH CARE REFORM

At the present time, there are four major reform proposals for restructuring the health financing system. These consist fo the single-payer system, the play-or-pay paln, the Heritage Foundations's tax credit proposal, and the managed competition approach.

### *Single-Payer Plan*

The single-payer approach creates a single pot into which all health care dollars flow. Administrators of this "pot" negotiate with hospitals and doctors. This single agency reimburses for all aspects of health care service. Providers, in effect, all contract with the same boss. One pot is used to pay everyone involved. This is a tax-based versus a premium-based system. Most often single-payer plans abolish private insurance and depend soley on

government administration. Other allow private companies to administer the public plan.

### *Play-or-Pay*

The play-or-pay system involves a combination of public and private systems that impose global budgets to limit cost and regulations to lessen inequities, along with mandates on employers to expand their coverage. The name "play-or-pay" comes from the idea that employers either offer health insurance("play"), or pay a new payroll tax between 5 and 8 percent, into the government's public system("pay"). When an employer opts to "pay", the employees are covered under the government's health care plan.

### *Tax Credit or Voucher System*

The Heritage Foundation tax credit or voucher system emphasizes a reintroduction of competition into the health care market. This plan is different in that workers pay directly for premiums. Health coverage is purchased directly from deductions taken against wages. These premiums are then considered legitimate tax deductions. Tax credits from the government are adjusted according to income level for individuals and families such that all sources of insurance, as well as out-of-pocket expenses are treated equally. Catastrophic insurance is required to be purchased by heads of households. By encouraging the use of a single, universal insurance claims form, this plan may help limit malpractice suits and "experience ratings" by insurers. This could produce overall cost reductions. This plan differs from play-or-pay in that it leaves the reform process to the private market, rather than to government regulation and administration.

### *Managed Care*

The fourth option is the managed competition proposal, and this is generally considered the basis of most plans favored by reformers at this time.

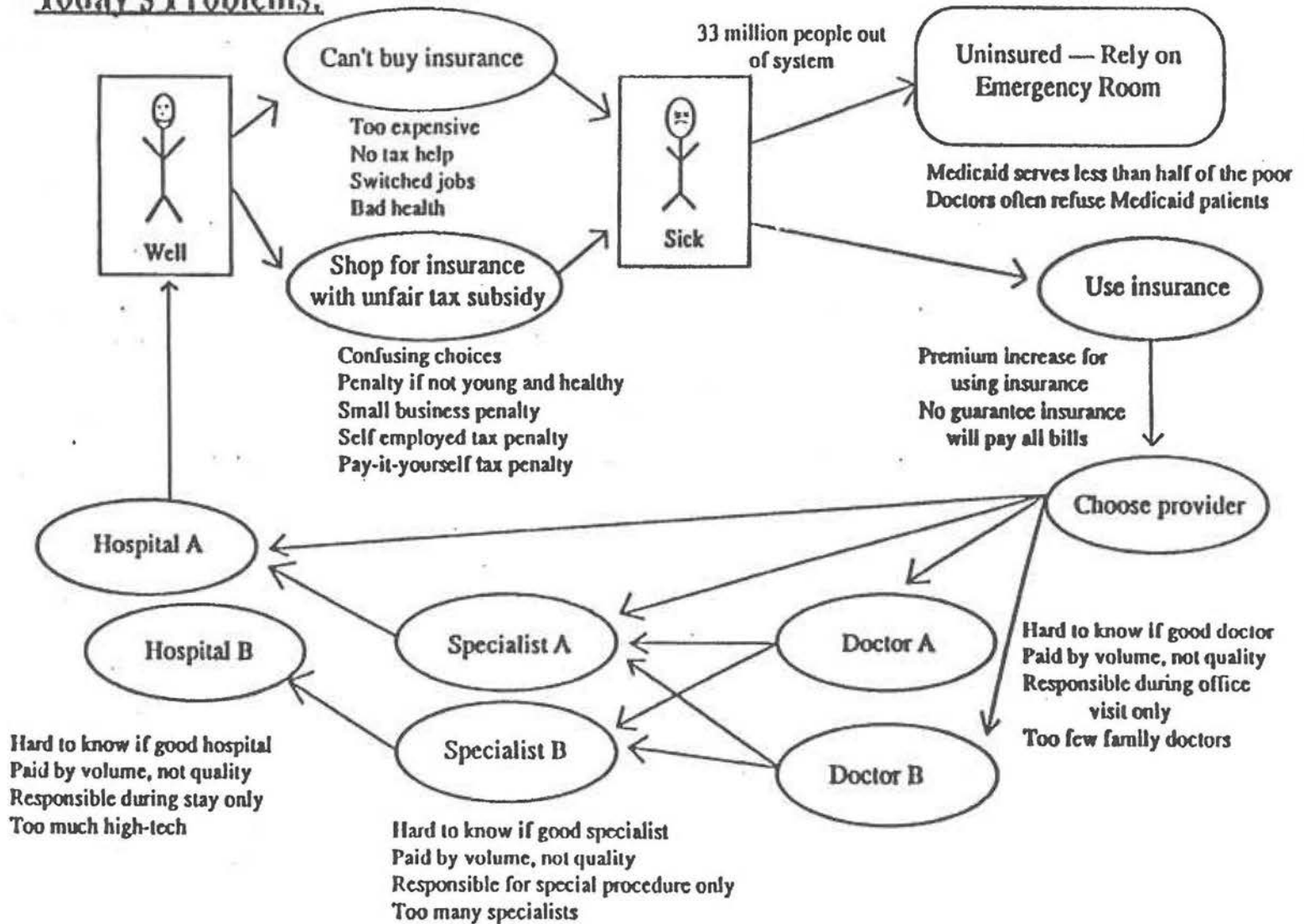
Managed care seeks to change market incentives for both providers and consumers by grouping consumers into large purchasing cooperatives. These groups are called regional Health Insurance Purchasing Corporations (HIPCs). They would evaluate providers, negotiate rates, and offer their members a choice between the best plans. States then would regulate HIPCs. The health plans themselves would be orchestrated to ensure some minimal level of quality and would emphasized cost reductions. "Accountable health plans" would only be certified by a national board who determines what a standard benefit package would be. Tax credit would be given if a consumer were to buy one of these certified plans. Employers' deductions of their contributions would be restricted. An employer would need to offer at least two certified plans; the employers' tax deduction limited to the cost of the cheapest certified plan in the region. The idea is to direct consumers toward less costly managed care plans (like HMOs) by limiting tax deductibility to the lower cost options. In theory, this would make health care more cost effective.

Managed competition has its share of problems. Many are concerned that added levels of intermediate bureaucracy will be developed. The possibility that this will lend to increased administrative costs, as managed care networks have done at the micro level, is real. Finding a way to pay doctors less is one thing, but should we pay insurers more? Competition is normally known to drive prices down; health care, however, has proven the opposite.

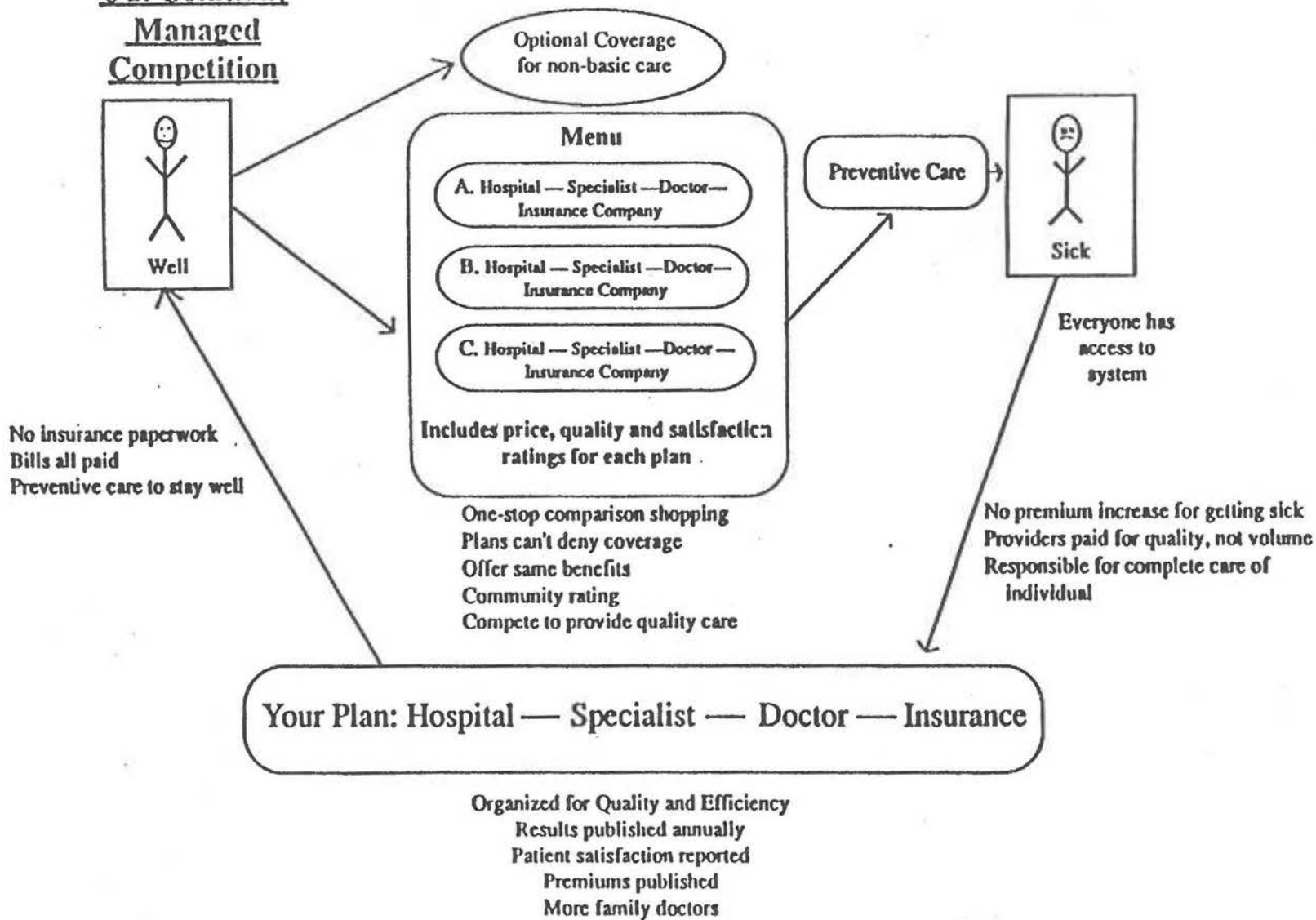
### *Summary*

All of the plans are national in scope and claim to allow access by all Americans. This is referred to as universal coverage. The single-payer and play-or-pay proposals require government regulation of prices and place limits on health spending. The tax credit and managed competition ideas use improved market incentives to contain costs; although with a watchful eye from government. The play-or-pay and managed competitions proposals

**Today's Problems:**

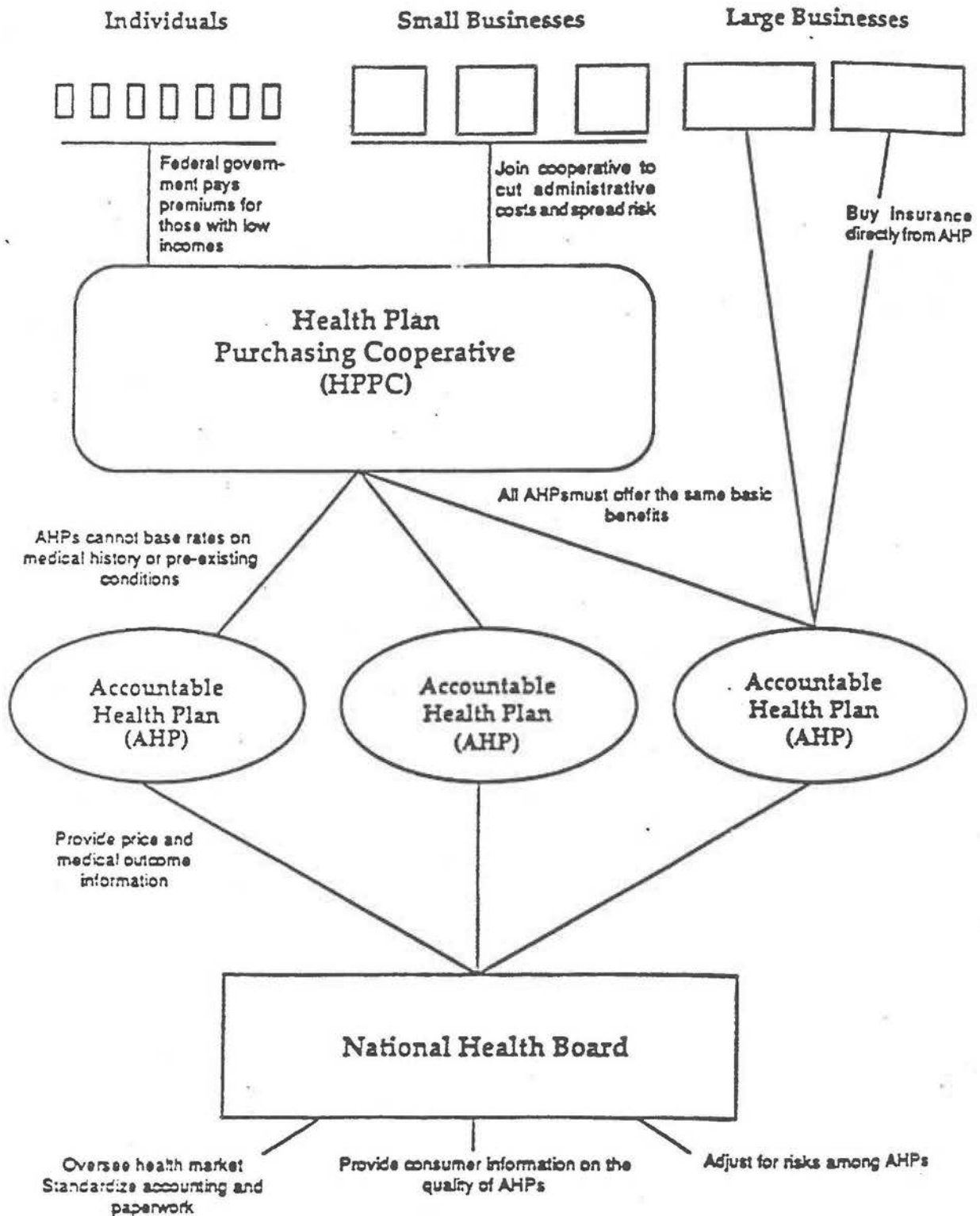


**Our Solution:**  
**Managed**  
**Competition**





# MANAGED COMPETITION



preserve employer provision of health benefits; the single-payer and Heritage plans close the employer system. Single-payer is a liberal approach, while the Heritage Foundation tax credit, conservative. Play-or-pay and managed competitions plans try to fall dead center.

## PROSPECTS FOR A MANAGED CARE APPROACH

Managed care deserves a more in depth review because of its prominence and attention in being the plan President Clinton would like to institute. Managed care is a confusing proposal, and it seems appropriate to provide some definitions at this point.

### Some Explanations of Managed Care

#### *The Contracting Parties In Managed Care*

Contracting involves a compromising exchange process where each participant attempts to optimize a certain set of objectives. Contracts can then be looked at as "conditions of participation" in any health plan. The four basic parties involved in these negotiations are:

1) *Consumers*: Those receiving either direct medical care services or reimbursement for use of services, as part of an organized benefit program. These persons vary by nature of their situation; whether they are employees, retirees, disabled, income dependent, etc..

2) *Sponsors*: The employers (or unions) who sponsor group health benefit plans and pay the major portion of its continuing costs-which includes administration and expenditures for the actual medical care rendered.

3) *Providers*: The independent clinical professional (e.g. physicians) and institutions (e.g. hospitals) that furnish services to the consumer.

4) *Intermediaries*: These groups act, at a minimum, as the middleman in administration between sponsor, consumer, and provider; they see to it that bills are paid. These entities can also be responsible for coordinating, managing, and integrating activities of the providers. These groups include a range of corporations: traditional insurance companies, managed care plans (e.g., HMOs), and third-party administrators.

All of these parties take financial risks to be involved in this system. First, the sponsor as the major financier (being either the employer or the government) incurs ongoing administrative expenses, which are relatively fixed, constant, and somewhat predictable. Additional expenses also accrued are payments for medical plan members. Most employers share the risk for this care-related expense with their employees by requiring payment of a portion of anticipated expenses before care is given and/or by requiring a variety of cost-sharing options once services are rendered.

The intermediary's financial risk is somewhat minimal. Its function is to manage the flow of funds. Profit is derived from fees for management services. The greatest risk for the intermediary come under traditional indemnity plans or a traditional HMO model, where all services are paid from premium revenues. If too many clients require services, the finances for intermediary services may be hard to find. Middle ground comes when the intermediary shifts this risk to one of the other parties, usually the consumer/provider.

Consumers are very tentative when it comes to the subject of risk. In the past, they have faced only moderate risk under most private indemnity plans and Medicare, because deductibles and coinsurance were reasonable. This is changing as employers are shifting the cost of care to become more of the patient's responsibility.

Provider's financial risk has only recently come into play in relationship to the managed care system. Financial risk is definitely highest when a provider agrees to a budgeted payment where all necessary care must be delivered in return for a fixed annual fee. Middle ground comes when arrangements are made on a per case fee payment system (like Medicare's fees for diagnosis-related groups of treatments). Here providers are paid according to a revised fee-for-service system. The more patients the provider sees, the greater the amount of compensation. There is a risk of penalty or reward, depending on the retrospective measure of their efficiency.

Other issues must also be looked at in regards to the managed care approach. One such issue is the consumer's freedom of choice. The consumer's ability to choose a caregiver is not restricted under most traditional fee-for-service indemnity plans; services can be sought from any licensed provider in the U.S.. The opposite is when the consumers' choices are at maximum restriction with a closed plan such as an HMO or exclusive provider organization (EPO). In these plans, consumers must choose a provider from those employed or contracted by the plan. A midpoint comes with managed care arrangements (e.g., POS or point-of-service plans) that offer incentives to use certain providers. Still, the consumer can seek services from other providers, but typically must pay for some of that service out-of-pocket.

Another issue is the provider's practice choices. Practitioners treasure their autonomy: the freedom to independently prescribe and administer clinical services shaped only by ethics, medical science, and marketplace interest. The common thread of all managed care plans is an extensive system of utilization controls. Services are defined, treatment approaches are specified, and formularies are often limited. Such programs subject patient's use of services and provider's practices to external review. These controls are

intended to "manage" the patient's care and ultimately the sponsor's resources. Cost containment is the reasoning behind the approach. This may lead to restrictions on practitioner's clinical options. Obviously restrictions are minimal in traditional indemnity plans. Since many private and public insurers are beginning to use some utilization controls, the line between "managed" and "non-managed" care has faded slightly. Usually this line is crossed when authorization must be obtained from the intermediary before services or referral to another provider is allowed.

The basic objective of any managed care plan is to manage utilization and price by controlling type, level, and frequency of treatment by capping the level of reimbursement for these services. Basic in these plans is the financial incentive for physicians to provide cost-effective care. Added to this is the fact that this must be achieved without sacrificing quality or access. But, reality is and has shown that the U.S. health care system is administratively inefficient; its broken up, complex payment system is at its very roots, expensive.

## OPTOMETRY + HEALTH CARE = ?

Overall, consumers don't view purchasing health care in the same way they do other purchases. Doctors end up making the choices, and consumers aren't sensitized to costs since private insurance picks up the tab. Doctors are influenced in their choices by science and legal (malpractice) issues. Physicians may tend to overuse technology and services to cover all the bases.

Providers end up increasing the demand for more complicated forms of health care. The supplier increases the demand, and the price per unit of consumption goes up. Insurance then provides the insulation between consumer and provider, and neither worries about cost containment.

Today, little of the American health care budget is spent on preventative medicine. Typically, considerably more money is expended on "fixing" the problem than on not allowing it to happen in the first place. Administrative costs keep escalating from 10 to 30%. The nation consists of a large percentage of specialists (70%) because providers find this to be a more lucrative field versus the 30% of primary care providers.

One version of the Clinton proposal seeks to provide universal coverage for everyone except undocumented aliens. It features a wide range of services, long term care for the disabled, and tax credits for small businesses who sign up (part of the play-or-pay plan). There would be certain limitations on initial dental, eye, and mental health care but these would be included in the governmental reimbursement plan. Free preventative care would be offered for some patient groups, most notably expectant mothers. The President indicates a commitment to trying to offer a choice of benefit plans to the consumer.

The expense of this plan would come from varied sources. Business would be required to pay 80% of premium costs for employees. This would not be allowed to go above 7.9% of total payroll-at least initially. Co-payments would be billed directly or obtained through the withholding portion of the employee's paycheck. Self-employed persons would pay the total premium. As for consumers who want a high cost plan, they would in turn also pay a higher deductible. The reverse then is also true, a low cost plan would have no deductible. A third option also exists whereby 20% of all expenditures would be paid by the consumer.

## *Optometry's future*

Medicare has recognized optometrists as physicians since 1987. It is very likely that when health care reform happens, optometry will be included. Optometrists are looked upon as primary eye care providers and with the advent of a broadening scope of practice (i.e., treatment and management of ocular disease using pharmaceutical agents), optometrists are well positioned for the role of gatekeeper in the new system. It will be the role of the optometrist to be the point of entry into a vertically integrated system involving primary eye care, and screening referrals to secondary and tertiary ophthalmology.

Health analysts expect any universal health plan to include coverage for some prescription drugs, limited dental care, abortion, hospitalization and physician care. Optometry would probably be included under physician care services.

It is estimated that any new health plan will cost at least \$40 billion a year. This will likely be funded through mandates upon employers, through Medicare cuts, and through additional taxes. Optometrist could benefit because they will probably see more patients. The downside is that the reimbursements will be reduced to keep costs in check. The good news is that everyone (including optometrists) will have access to some guaranteed level of health care and to major medical hospitalization. At least this is the theory. How the limited resources can be allocated for a limitless demand, is yet to be explained.

In Canada, federal law leaves the specifics of coverage and administration to the provincial governments. It isn't quite the same in the United States.

Unless the new policy is stated nationally in the U.S., optometry could be excluded as primary gatekeepers by HMOs in some states.

## ENDING

“It is easy to imagine that a reform like national health insurance offers a definitive solution, a final policy destination. In politics, there is no such thing. In a field as complex as health care, all reforms solve some problems and exacerbate others. Every political innovation leads to a new policy debate.” James A. Morone



## REFERENCES:

- Journal of Behavioral Optometry*, Vol. 5, No. 5, Fall 1994.  
Copyright 1994 by Optometric Editors Assoc.
- Journal of Health Politics and Law*, Vol. 18, No. 1, Spring 1993.  
Copyright 1993 by Duke University.
- Journal of Health Politics and Law*, Vol. 18, No. 2, Summer 1993.  
Copyright 1993 by Duke University.
- Journal of Health Politics and Law*, Vol. 19, No. 1, Spring 1994.  
Copyright 1994 by Duke University.
- Optometric Economics*, Vol. 3, No. 10, October 1993.  
Copyright 1993 by American Optometric Association
- Review of Optometry*, Vol. 130, No. 7, July 15, 1993.  
Copyright 1993 by Chilton Publishing Co.
- Review of Optometry*, Supplement, September 15, 1994.  
Copyright 1994 by Chilton Publishing Co.
- American Academy of Optometry 1993 Annual Meeting. Symposium:  
Present and Future Health Care Policies and Their Relevance  
to Optometry by *Thomas Pyle*, *Rashi Fein, PhD, Congressman*  
*Mike Kreidler, O.D.*, and *Lynn Becker, Esquire*.
- Most **Definitions** taken directly from *Journal of Politics, Policy and Law*,  
Vol. 18, No. 1, Spring 1993. Copyright 1993 by Duke University.  
and an article titled *Synergy* published by Epstein Becker & Green,  
Spring 1993 received at the American Academy of Optometry  
Meeting in December of 1993.