

# HEALTH CARE REFORM SIMPLIFIED

GUIDE YOUR FAMILY AND YOUR BUSINESS  
THROUGH HEALTH CARE REFORM

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*Dave Parks*

Apress®

## ***Health Care Reform Simplified***

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*To the health care providers who are still able to  
put their passion in compassion.*

# Contents

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<b>About the Author</b> .....	vii
<b>About the Technical Reviewer</b> .....	viii
<b>Acknowledgments</b> .....	ix
<b>Introduction</b> .....	xi
<b>Chapter 1:</b> Overview: Health Care Reform Past and Future.....	1
<b>Chapter 2:</b> Early Changes: Health Care Reform’s First Ups, Downs .....	21
<b>Chapter 3:</b> New Choices: Individual, Family Insurance Options .....	37
<b>Chapter 4:</b> Business Trends: Tackling Taxes, Mandates, Incentives .....	57
<b>Chapter 5:</b> Insurance Shift: Law Changes Market Rules, Regulations.....	77
<b>Chapter 6:</b> New Medicine: Law Attacks Errors and Inefficiencies .....	91
<b>Chapter 7:</b> Medi-Growth: Medicaid, Medicare Poised to Expand.....	105
<b>Chapter 8:</b> Info Overload: Law Brings Communication Challenges .....	117
<b>Chapter 9:</b> Who Pays: Health Care Reform to Cost \$1.4 Trillion .....	127
<b>Chapter 10:</b> War on Reform: New Law Faces Legal, Political Attacks .....	137
<b>Bibliography</b> .....	147
<b>Index</b> .....	161

# About the Author

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**Dave Parks** has more than 25 years of experience as a journalist, and he has earned numerous awards for his coverage of some of the most important medical issues of our time. His investigative reporting about health problems found, but ignored, in veterans of the 1991 Persian Gulf War led to a White House investigation, Congressional hearings, and changes in how the military screens troops medically before and after battle. He has written in-depth, groundbreaking stories about cancer survivorship, health disparities, cervical cancer prevention, and liver transplantation. He has worked as an editor and writer in the Midwest and the Southeast, and he has traveled to some of the deepest reaches of Africa to cover the AIDS pandemic. He is a member of the Association of Health Care Journalists and the American Medical Writers Association.

# About the Technical Reviewer

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**Beth Brophy** is a writer and editor who writes frequently about health issues. She is an associate editor and the podcast producer for *Health Affairs*, a leading health policy journal. She has been a senior editor at *US News and World Report*, a columnist for *USA Today*, and a reporter at *Forbes* magazine. She is the author of two non-fiction books and a novel. She lives in Chevy Chase, MD. Her BA is from William Smith College, and she has a master's degree in journalism from Northwestern University.

# Acknowledgments

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I'm always a little sheepish about putting my name on any collaborative work of journalism, which in my mind includes nearly all writing found in books, magazines, and newspapers. It may be necessary to name the author of a work, but a single byline takes for granted a complex editorial process. For a writer, the road to publication is filled with editors who vet, correct, and polish the work, not to mention graphic artists and skilled workers who also are in the production cycle. At least four editors gave constructive criticism, checked facts, copyedited, and supplied technical support for this book. Along with improvements, they also provided words of encouragement. I thank them.

This book also was made possible by a host of sources—print journalists, bloggers, medical authorities, and policy experts who produced a mountain of articles and papers about day-to-day developments and trends surrounding health care reform. I've listed many of them in the bibliography, but it would be difficult to name everything I've read on such a pivotal issue. Please forgive any omission.

As with any book like this, a writer must depend upon some trusted sources. Fortunately for me, the Henry K. Kaiser Foundation, the Commonwealth Fund, and the Robert Wood Johnson Foundation provided Internet portals leading to a massive body of studies, articles, graphs, charts, and papers on health care reform. In many ways foundations provided the foundation for this book. Understand though, that these private foundations do approach the subject of health care reform with a point of view toward promoting a medical system that provides the best service to the most people at the most efficient cost. To many people those would be laudable goals, but health care reform is a contentious issue with many diverse points of view. Still, these foundations are generally non-partisan, and it's difficult to dispute most of the facts they provide.

Finally, I must acknowledge my family's impact on my own point of view in writing this book. In recent years I watched as my mother and father aged,

grew frail, and came to depend upon American medicine. I saw the best and the worst of the system. My parents are both gone now, leaving behind a final, influential lesson in courage, compassion, and care. I must thank my wife, Barbara, a registered nurse, for her patience, support, and wisdom. Additionally, I tested many of my writing approaches on my son, Mitchell; daughter, Laura; and son-in-law, Nick Wong. They may not have known it, but their responses helped shape my attempts to explain a complicated subject.

# Introduction

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It's November 2004, and I'm in an operating room at the University of Alabama at Birmingham Hospital watching a 57-year-old Alabama school teacher slipping into the emptiness of anesthesia. She's grasping a vision of life, of a grandson nestled in her arms. "I'm holding my baby here," she says, her voice relaxed and peaceful amid choreographed movements of doctors, nurses, and medical technicians. An anesthesiologist places a mask over her face. She inhales and fades away.

More than six hours later, she awakens in an intensive-care bed and has a transplanted liver, along with the opportunity to again hold grandchildren close and feel love, hope, and humanity. She is among more than 65,000 Americans who have undergone this dramatic operation since 1988. The cost: roughly a quarter million dollars each.

A few months later, I'm standing in tropical humidity, among single-story, whitewashed buildings comprising Lewanika General Hospital in Western Zambia. I'm in an outdoor waiting area that is packed with members of the Lozi Tribe, people who still live in picturesque villages of grass huts in sub-Saharan Africa. There are few chairs, and people mostly stand or sit on cement sidewalks. Chickens living on the hospital grounds occasionally squawk their way through the crowd. Two women wail pitifully, having just received word of a death.

About a dozen mothers sit on gurneys and nurse newborns in a ward that is nothing more than a long, open room. Two nurses in starched, white uniforms walk the hallway wearily. They work thirteen-hour shifts, four days a week, and earn the equivalent of \$25 a week. The hospital lacks oxygen equipment, thermometers, blood pressure machines, and basic pharmaceuticals such as antibiotics. Patients are asked to bring their own drugs if they can afford them. Equipment in surgical suites is old and worn, with rubber cracked and crumbling.

The United States has one of the richest health care systems in the world, and Zambia one of the poorest. Zambia spends \$80 a year per person on health care; the United States spends more than \$7,000. Both countries struggle to provide enough good quality health care for everybody.

Zambia has been reforming its health care system since 1992. It's been tough. About one in seven of Zambia's adults live with HIV/AIDS. There's no insurance to speak of, and if policymakers raise the price of care, nobody can afford it; if they drop the price to nothing, patients swamp the system. There's only so much to go around, and in an impoverished nation, few people can afford to pay much of anything, particularly in rural areas.

America is reforming its health care system, too, with the Patient Protection and Affordable Care Act of 2010. The United States has the most expensive health care on earth, but the quality and quantity can be spotty.

Extraordinary medicine, probably the best in the world, is practiced at places like the Cleveland Clinic, Mayo Clinic, or the Johns Hopkins Medical Center, but many publicly supported hospitals for indigent care can be pretty Spartan. Go to impoverished rural areas of a state like Alabama, and medicine gets even more basic—and scarce. Medical errors are a problem everywhere.

Be assured, though, from the bush of Zambia to a modern operating room of an American medical center, there is a fundamental drive among people to provide each other with decent health care. It's a basic human value. Who pays is another matter entirely, particularly in America.

For example, a 2009 CBS News Poll found that 64 percent of Americans believe the government should guarantee health insurance for everybody. Fine, but a Penn, Schoen, and Beland Associates Poll the same year asked people if they were willing to pay more taxes to guarantee this health coverage, and the same exact same portion of Americans, 64 percent, said no.

Still, if somebody shows up at a hospital emergency department in the United States with a medical need and he can't afford to pay, he must be seen. A sense of common decency among Americans led to a law, enacted 25 years ago, requiring hospitals to accept these types of patients. Most people didn't realize it at the time, but that was a turning point in American medicine, when the nation decided that everybody deserved some level of care.

It is called the Federal Emergency Treatment and Labor Act of 1986. It requires hospital emergency departments to provide examination and, if needed, emergency care, regardless of ability to pay. The care, which is usually uncompensated, doesn't end at the emergency department. If a woman comes in about to have a baby, she stays at the hospital until the baby is delivered. If a man comes in riddled with gunshot wounds, he goes to surgery and stays in the hospital until he can be safely discharged.

The U.S. Supreme Court has ruled on the law, and left it intact. But the law is criticized because at times it appears to open the U.S. health care system to exploitation. Studies show that up to 55 percent of an emergency physician's time may be spent delivering this care after doing tests to determine if these patients have an "emergency medical condition" – a term that has a fuzzy legal definition. This contributes significantly to emergency department overcrowding, and the law does not provide a way to pay for exams and care. We all foot the bill in one way or another. And to make things worse, this type of crisis care is extremely expensive and often would be unnecessary if the patient had decent medical care to begin with.

Still, the law stands, and the current debate is not over whether we should provide care to everybody. It is about where the care is going to be delivered, how good the care is going to be, and how we are going to pay for the care. It's also about what we are going to do about more than 50 million Americans who lack insurance.

We're trying to find a way to make our health care system work in a humane way for patients, an affordable way for consumers, and a profitable way for insurers and providers. We want all this, and we also want to keep the miracles of modern American medicine. We want high-ticket procedures like \$750,000 heart transplants, \$325,000 open heart surgeries, and \$150,000 eye operations. We want more preventive care for everybody. We want fewer medical errors, and more evidence-based treatments. And we want lower medical costs and insurance premiums, with taxes for health care kept to a minimum.

That's a pretty tall order for a complex, \$2.3 trillion-a-year medical system.

Already, a year into health reform, we're seeing how complicated the process can be. Under the new health laws, insurance exchanges were temporarily established in 2010 for uninsured people with pre-existing medical conditions. The U.S. Department of Health and Human Services

predicted that 375,000 people would be enrolled at these exchanges by the end of 2010. By February 2011, the enrollment stood at about 12,000.

It's a living demonstration that better and more available insurance doesn't always translate into fewer uninsured people. Cost is always an issue, but so too are culture, faith, education, awareness, and trust.

For example, when American doctors first arrived in Zambia to help with the AIDS pandemic, they established a clinic in Lusaka, a city with a population of over 3 million, and started taking blood samples from Zambians to see if they were HIV positive. Soon, people stopped coming to the clinic. When doctors asked why, Zambians said word had gotten out that their blood was being used in demonic rituals.

That's less preposterous than it sounds. In this country, some people belong to religions that view medical care as a sin. Other people just plain mistrust modern medicine, and wouldn't go to a doctor if you paid them. Others may be unaware of choices—the main problem with low enrollment at the new insurance exchanges for people with pre-existing conditions, federal officials say.

This goal of this book is to raise awareness about what the Patient Protection and Affordable Care Act of 2010 offers different people in different circumstances in as simple a way as possible. It explains how the new health law came into existence, what it provides, and its possible future. The book does not intend to judge whether the new law is good, bad, or ugly. It's about what the law means to individuals, families, businesses, and Medicare and Medicaid recipients. It also explains the impact of the law on insurers, hospitals, and doctors—and how that may affect patients.

It will provide information on new health insurance exchanges, mandates for individuals to have insurance, penalties for failure to have insurance, options for businesses to cover their employees, and much more.