Health Care Finance, Economics, and Policy for Nurses
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To my students, whose questions encourage me to try ever harder to make finance, economics, and policy understandable and useful.
CONTENTS

Foreword  Susan B. Hassmiller, PhD, RN, FAAN, and Susan Reinhard, PhD, RN, FAAN  xi
Preface  xiii
Acknowledgments  xxiii

SECTION I. THE CONTEXT OF HEALTH CARE AND HEALTH CARE REFORM  1

1. What Is Health Economics and Why Is It Important to Nurses?  3
   Theoretical Economic Approaches  4
   Social Determinants of Health  6
   How Economics Differs From Financing and Reimbursement  8
   Insurance Industry Changes Since the Passage of the ACA  16
   Conclusion  21

   The Influence of the Flexner Report  29
   Early Hospitals  31
   Social Reform Addressing Unintended Consequences of Employer-Based Insurance  32
   Attempts to Change Financial Incentives to Contain Costs  36
   The ACA and New (and Renewed) Payment Models  39

3. Payment Reform  47
   From Volume to Value: Payment Models That Move Away From Fee-for-Service Reimbursement  48
   Nursing Roles Within Emerging Payment Models  62
SECTION II. HEALTH CARE ECONOMICS: AN OVERVIEW  69

4. How Health Care Markets Differ From Classic Markets  71
   What Does It Mean to Bear the Consequences of Financial Decision Making?  71
   What Ideas Help Us Understand Overtreatment? The Example of Small-Area Variation and Supplier-Induced Demand  79

5. The Role of Information in Health Care Markets and Decision Making  87
   The Need for Information  87
   Data on Quality  92
   Big Data  94
   Meaningful Use  97
   Information Science, Quality Science, and Data  98

6. Market Entry, Exit, and Antitrust Law  105
   Entering and Exiting the Market  106
   Merge, Consolidate, or Stand Alone: An Overview of Antitrust Law  110
   Is Consolidation the Same as Integration?  111

SECTION III. ETHICS AND ECONOMICS IN AN AGE OF REFORM  117

   Can Economics Coexist With the Intention of “Doing Good”?  119
   Social Determinants of Health, Health Disparities, Ethics, and Economics  122
   Moral Conduct of Nurses in Contemporary Complexity  126

8. Additional Models to Guide Ethical Decision Making  135
   Consequence-Based Decision Making  136
   Deontology: Rule-Based Decision Making  137
   Virtue Ethics  138
   Using These Models in Clinical Decision Making  138
   Moral Distress  141
   Ethics of Reform and Cost Containment  142
   Sustainability Is an Ethical Issue  144
   Nurses on Boards and in Politics  145
SECTION IV. PULLING IT ALL TOGETHER: USING YOUR KNOWLEDGE OF HEALTH FINANCE, ECONOMICS, AND ETHICS TO INFLUENCE HEALTH AND HEALTH CARE 151

9. Governance and Organizational Type 153
   Role of the Board of Trustees 154
   Types of Hospitals and Health Systems 156
   Navigating Governance–Management Boundaries 160
   The Relationship Between Organizational Structure and Organizational Values 164
   The Role of Board Committees 165
   The Sarbanes–Oxley Act 166

10. Building Skills for Board Membership 173
    Zeal, Organizational Fit, and Philanthropy 173
    Types of Board Appointments 174
    What a Governing Board Is Not 175
    Other Types of Boards 176
    Building the Skill Set for Board Membership 177
    Next Steps 188

11. Applying Health Economics to Influence Health Care Through State and Federal Policy Formation 193
    Ways of Influence 194
    How to Contact Policymakers 197
    Maintaining a Connection with Policymakers to Influence Health and Health Care 201
    Overcoming Impediments to Involvement 201

    Tell Me One More Time: What Does All This Financing, Economics, and Policy Have to Do With Nursing? 209
    How to Retain and Expand on What You Have Learned 211

Appendix: Quiz Answers 213
Glossary 217
Index 223
As we travel around the country to promote nursing leadership, we hear a familiar refrain from health care leaders: Nurses bring strategic planning skills, sound clinical knowledge, and an ability to respond to crisis to boards and policy-making tables, but nurses must also possess business acumen to be considered for top leadership positions. They must understand policy making, negotiation and influence, and health finance, including the ability to read a financial statement.

That’s why *Health Care Finance, Economics, and Policy for Nurses: A Foundational Guide* offers crucial knowledge to prepare nurses in RN-to-BSN and second degree programs to serve in leadership positions. As Betty Rambur eloquently explains, health care financing, economics, and policy making are foundational nursing knowledge in the 21st century, a sentiment clearly stated in the landmark Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine, 2011). Being exposed to Rambur’s book in nursing school will help to ensure that nurses are knowledgeable in business and finance skills and understand the importance of pursuing leadership positions to better serve patients, families, and communities.

Our organizations, the Robert Wood Johnson Foundation and AARP, are spearheading The Future of Nursing: Campaign for Action, a national initiative to improve health through nursing by advancing the recommendations in the IOM report. We are delighted that 19 national nursing organizations have joined us in forming the Nurses on Boards Coalition to place 10,000 nurses on boards by 2020. Nurses bring unique competencies to boards and policy-making tables, including community orientation, collaboration, organizational awareness, accountability, team leadership, relationship building, negotiation skills, and professionalism. They also have knowledge and skills to track measures of quality, safety, and customer satisfaction in health care delivery and performance. Equally important, nurses bring the consumer’s voice to the fore and are driven by a lifelong commitment to
FOREWORD

human caring—and that should be the cornerstone of all efforts to improve health and health care. Nurses are the reality check in any decisions being made that affect the delivery of care and the promotion of health.

However, few nurses serve on boards: The American Hospital Association estimates that nurses fill 6% of board seats, compared with 20% for physicians (AHA, 2010). Health Care Finance, Economics, and Policy for Nurses: A Foundational Guide will help to change that by teaching nursing students early on that business and finance skills are a requisite for their careers. It should be required reading in every school of nursing in the United States. We hope that faculty members will embrace this book, and that nursing students who read the book will be inspired to pursue leadership roles and make it their goal to sit at tables where they can truly effect change and advance health.

Susan B. Hassmiller, PhD, RN, FAAN
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Director, Campaign for Action

Susan Reinhard, PhD, RN, FAAN
Senior Vice President and Director, AARP Public Policy Institute
Chief Strategist, Center to Champion Nursing in America

REFERENCES


PREFACE

A NOTE TO THE READER

Health care financing, economics, and policy are foundational to nursing knowledge in the 21st century. The Essentials of Baccalaureate Education for Professional Nursing Practice by the American Association of Colleges of Nursing (AACN, 2008) states, “Baccalaureate generalist nurses are designers, coordinators, and managers of care” (p. 9). These skills, in turn, depend on sound understanding of health financing, economics, politics, and policies, as well as new systems of care fueled by emerging payment models. To design, coordinate, and manage care as the Essentials require, nurses must understand the Affordable Care Act of 2010 and its implications for patients, nursing practice, and health care. We must be agile enough to work with a range of payment and delivery reform models—from fee-for-service-based, patient-centered medical homes; accountable care organizations with or without shared saving programs; and pay for performance to post-fee-for-service models, such as like bundled payments and global budgets. We must understand why hospitals are merging, and what this means to cost, outcomes, and nursing practice. This text provides you, the reader, with the knowledge to artfully navigate this terrain through foundational understanding of the finance, economics, and policies that shape health reform, as well as our daily lives as nurses and citizens.

This knowledge is so important that one entire “Essential” in The Essentials of Baccalaureate Education is devoted to it: “Healthcare Policy, Finance and Regulatory Environments” (Essential V). This “Essential” notes, “Healthcare policies including financial and regulatory policies, directly and indirectly influence nursing practice as well as the nature and functioning of the health care system....The baccalaureate-educated graduate will have a solid understanding of the broader context of health care, including how patient care services are organized and financed, and how reimbursement is structured” (AACN, 2008, p. 20).
Yet many nursing programs struggle to incorporate this content in meaningful, tangible ways—a gap that Health Care Finance, Economics, and Policy for Nurses: A Foundational Guide is designed to address. Previous generations of nurses were not fully schooled in the issues of finance and, instead, were socialized to believe that nurses should not think about resources when considering patient care. Nor has the public fully expected nurses to think about finances and economics. Perhaps, we—as nurses—often do not even desire economic acumen, having from the beginning chosen a profession in which we perceive people, not money, to be at the center. Paradoxically, this creates tensions because financial incentives and disincentives shape individual and organizational behavior. Economics fuels the health care system, and finances etch every element of the health care workplace. Economics and patient care are inexorably linked.

So, leaving the finances and politics for someone else to worry about is no longer a viable or even ethical approach, catalyzing great urgency for this foundational nursing knowledge in the era of reform. Readers of this text will be well prepared to navigate the contemporary care landscape, armed with an understanding of ethical, patient-centered care within a resource-constrained environment. Readers will also be prepared to use the language and actions of influence—that is, the language of finance, economics, and policy.

The language and actions of influence are also necessary to redesign the health care system toward the 2001 goals of the Institute of Medicine (IOM) detailed in Crossing the Quality Chasm: A New Health System for the 21st Century: safe, effective, patient-centered, timely, efficient, and equitable patient care. Such redesign cannot happen with knowledge and skills developed in an episodic, fee-for-service, acute care–oriented world. As Einstein sagely notes, “We cannot solve our problems with the same thinking we used when we created them.” Fortunately, finance and economics are new thinking for many nurses. Thus, knowledge of economics, finance, and policy, joined with more traditional nursing knowledge, provides nurses with binocular vision; nurses are uniquely positioned to hold a view of the individual patient and family simultaneously with consideration of overarching population health goals and financial impacts on society at large. This is an enormously complex skill set, yet nurses—with knowledge of patients and systems—are ideally suited for the important social responsibility of knitting together the needs of the individual and society at large within a landscape that considers health, health care, cost, and quality. The central role of each and every nurse—yes, you—cannot be overstated. Fraher, Ricketts, Lefebvre, and Newton (2013) note that “because of sheer numbers—the U.S. health care system employs 2.7 million registered nurses—it is nurses who are arguably in the most pivotal position to drive systems change” (p. 1812). Society needs your clear-sighted nursing vision in this time of rapid change.
In addition to Essential V, there are other Essentials directly supported by material in this text. For example, Essentials II.3—“Demonstrate an awareness of complex organizational systems”—and II.4—“Demonstrate a basic understanding of organizational structure, mission, vision, philosophy, and values” (AACN, 2008, p. 14)—are addressed in Chapters 9 and 10 of this text. Other elements of this text provide important background material that can help you make connections among different domains of study and practice. Chapter 5, for example, details the role of information through the lens of economic, policy, and patient perspectives. In so doing, it provides supportive material for Essential IV, “Information Management and Application of Patient Care Technology: #12: Participate in evaluation of information systems in practice settings through policy and procedure development” (AACN, 2008, p. 19). Additional examples of links among text content and Essentials of Baccalaureate Education may be found in Table P.1.

### Table P.1
**Relationship Among Essentials of Baccalaureate Education for Professional Nursing Practice and Text Content**

<table>
<thead>
<tr>
<th>The Essentials of Baccalaureate Education for Professional Nursing Practice</th>
<th>Text Support, by Criterion</th>
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<tbody>
<tr>
<td>Essential I.5: Apply knowledge of social and cultural factors to the care of diverse populations.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential I.6: Engage in ethical reasoning and actions to provide leadership in promoting advocacy, collaboration, and social justice as a socially responsible citizen.</td>
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<tr>
<td>Essential I.7: Integrate the knowledge and methods of a variety of disciplines to inform decision making.</td>
<td>Direct</td>
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<tr>
<td>Essential I.8: Demonstrate tolerance for the ambiguity and unpredictability of the world and its effect on the health care system.</td>
<td>Indirect</td>
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<tr>
<td>Essential II.1: Apply leadership concepts, skills, and decision making in the provision of high quality nursing care, health care team coordination, and the oversight and accountability for care delivery in a variety of settings.</td>
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<tr>
<td>Essential II.3: Demonstrate an awareness of complex organizational systems.</td>
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<th>Relationship Among Essentials of Baccalaureate Education for Professional Nursing Practice and Text Content</th>
<th>Text Support, by Criterion</th>
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<tbody>
<tr>
<td>Essential II.4: Demonstrate a basic understanding of organizational structure, mission, vision, philosophy, and values.</td>
<td>Direct</td>
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<tr>
<td>Essential II.5: Participate in quality and patient safety initiatives, recognizing that these are complex system issues, which involve individuals, families, groups, communities, populations, and other members of the health care team.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential II.11: Employ principles of quality improvement, health care policy, and cost-effectiveness to assist in the development and initiation of effective plans for the microsystem and/or system-wide practice improvements that will improve the quality of health care delivery.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential II.12: Participate in the development and implementation of imaginative and creative strategies to enable systems of change.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential III.8: Acquire an understanding of the process for how nursing and related health care quality and safety measures are developed, validated, and endorsed.</td>
<td>Indirect</td>
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<tr>
<td>Essential IV.7: Recognize the role of information technology in improving patient care outcomes and creating a safe care environment.</td>
<td>Direct</td>
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<tr>
<td>Essential IV.11: Recognize that redesign of workflow and care processes should precede implementation of care technology to facilitate nursing practice.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential IV.12: Participate in evaluation of information systems in practice settings through policy and procedure development.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential V.1: Demonstrate basic knowledge of health care policy, finance, and regulatory environments, including local, state, national, and global health care trends.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential V.2: Describe how health care is organized and financed, including the implications of business principals, such as patient and system cost factors.</td>
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<td>Essential V.3: Compare the benefits and limitations of the major forms of reimbursement on the delivery of health care services.</td>
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| Essential V.4: Examine legislative and regulatory processes relevant to the provision of health care. | Direct |
| Essential V.5: Describe state and national statutes, rules, and regulations that authorize and define professional nursing practice. | Indirect |
| Essential V.6: Explore the impact of sociocultural, economic, legal, and political factors influencing health care delivery and practice. | Direct |
| Essential V.7: Examine the roles and responsibilities of the regulatory agencies and their effort on patient care quality, workplace safety, and the scope of nursing and other health professionals’ practice. | Direct |
| Essential V.8: Discuss the implications of health care policy on issues of access, equity, affordability, and social justice in health care delivery. | Direct |
| Essential V.9: Use an ethical framework to evaluate the impact of social policies on health care, especially for vulnerable populations. | Direct |
| Essential V.10: Articulate, through a nursing perspective, issues concerning health care delivery on decision makers within health care organizations and other policy arenas. | Direct |
| Essential V.11: Participate as a nursing professional in political processes and grassroots legislative efforts to influence health care policy. | Direct |
| Essential VI.4: Contribute the unique nursing perspective to interprofessional teams to optimize patient outcomes. | Indirect |
| Essential VI.5: Demonstrate appropriate teambuilding and collaborative strategies when working with interprofessional teams. | Indirect |
| Essential VII.10: Collaborate with others to develop an intervention plan that takes into account determinates of health, available resources, and the range of activities that contribute to health and the prevention of illness, injury, disability, and premature death. | Indirect |

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### Table P-1 (continued)

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<tr>
<th>The Essentials of Baccalaureate Education for Professional Nursing Practice</th>
<th>Text Support, by Criterion</th>
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<tbody>
<tr>
<td>Essential VII.11: Participate in clinical prevention and population-focused interventions with attention to effectiveness, efficiency, cost-effectiveness, and equity.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential VII.12: Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential VII.13: Use evaluation results to influence the delivery of care, deployment, and resources, and to provide input into the development of policies to promote health and prevent disease.</td>
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</tr>
<tr>
<td>Essential VIII.1: Demonstrate the professional standards of moral, ethical, and legal conduct.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential VIII.2: Assume accountability for personal and professional behaviors.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential VIII.3: Promote the image of nursing by modeling the values and articulating the knowledge, skills, and attitudes of the nursing profession.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential VIII.5: Demonstrate an appreciation of the history of and contemporary issues in nursing and their impact on current nursing practice.</td>
<td>Direct</td>
</tr>
<tr>
<td>Essential VIII.11: Access interprofessional and intraprofessional resources to resolve ethical and other practice dilemmas.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential IX.3: Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across the lifespan, and in all health care settings.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential IX.4: Communicate effectively with all members of the health care team, including the patient and the patient’s support network.</td>
<td>Indirect</td>
</tr>
<tr>
<td>Essential IX.5: Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences.</td>
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In 2010, IOM promulgated another set of important recommendations in The Future of Nursing: Leading Change, Advancing Health. Health Care Financing, Economics, and Policy for Nurses: A Fundamental Guide directly supports its key recommendations, for example, the call for the health care system to serve society better through opportunities for “nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts” (p. 1). To be a full partner requires solid grounding in “how the money works”—a core focus of this text—given that finances are a sort of oxygen feeding elements of the health care system. Notably, what is fed will grow; what is not financially fed will wither.

The 2010 IOM recommendations assume substantial payment and delivery literacy, for example, the recommendation that “The Centers for Medicare and Medicaid Innovation should support the development and evaluation of models of payment and care delivery that use nurses in an expanded and leadership capacity to improve health outcomes and reduce costs” (p. 11). To attain this outcome, nurses must be conversant with the
payment models defined in this text and recognize meaningful potential adoptions in their own practice or leadership role.

Nurses have filled many bedside and managerial roles for decades. Yet another key IOM 2010 recommendation envisions more comprehensive leadership roles for nurses: “Public, private, and governmental health care decision makers at every level should include representation from nurses on boards” (p. 14). Nonetheless, many nurses are unfamiliar with how to access board roles, are unaware that they exist, or do not have governance or regulatory aspirations. To fill this gap, this text—unique among contemporary materials—offers two chapters devoted to developing nurse awareness of the structures, processes, and appointment avenues for governance, advisory, and regulatory boards. In accessing board membership, one may consider Florence Nightingale’s apt dictum on what a nurse must keep in mind: “…not, how can I always do this right thing myself, but…how can I provide for this right thing to always be done?” (cited in Ulrich, 1992, p. 38).

Finally, although clinical ethics is a domain most nurses and nursing programs are prepared to consider, the interplay among ethics, economics, and health reform is not. Indeed, the area of ethinomics, the intersection of ethics and economics, is uncharted territory for many nurses. This text is designed to provide nurses with the ethical tools to consider the intersection of the individual and population care, overtreatment and undertreatment, metric-driven harm, and the economic impact of clinical decision making on equality of opportunity in other domains of individual and population life. Although there are no easy answers, the hope guiding this text development is that the nurse will have better questions and heightened awareness, perhaps even seeing ethical dilemmas in what once seemed commonplace practice. Such discernment builds moral muscle and is the first step toward heightened ethical efficacy and moral health. Taken as a whole, health economics, finance, and politics, applied from bedside to boardroom, locally to internationally, enables nurses to assure that the right thing is always done, just as Florence Nightingale advised.

**How This Book Is Organized**

Chapters 1 and 2 provide an introduction to health economics and develop foundational terms and concepts, such as financing, reimbursement, and payment. The reader is asked to be patient with these materials, as they form a sort of foundation to the broader health care story and nursing practice. Understanding the evolution of financing, reimbursement, and payment within the U.S. health care system, including a pattern of potential solutions leading to unintended consequences, helps the reader place the contemporary
health system within a broader historic milieu. This historic understanding is important, as many valued as well as problematic aspects of health care are rooted in the past; such understanding enables you to better navigate change as well as lead it.

Chapter 3 provides an overview of payment reform models, which are then explicated in Chapters 4 through 6 by contrasting the more familiar classic free markets and health care markets. This knowledge thereby provides a context for understanding aspects of the Affordable Care Act and state reform efforts, both now and in the future. Chapters 7 and 8 interlace these issues with ethical perspectives and models for ethical decision making.

You are now prepared to apply what you have learned to leadership positions on boards and to the policy process. Thus, Chapters 9 through 11 offer practical, tangible advice on how this more profound sense of self can be used by the nurse in governance and policy settings. Chapter 12 offers closing thoughts on how to embrace continuous learning in these areas to ensure that you bring your knowledge into the world in vital, immediate, impactful ways throughout your entire professional career.

Each chapter includes vignettes that illustrate complex economic and financial concepts in scenarios that are familiar to everyday life. These vignettes offer a bridge between your existing common knowledge and financial and economic material that may otherwise seem like a foreign language in a foreign land. The approach is designed to help the reader successfully translate known concepts and processes to new financial, economic, policy, and regulatory terrain. Each chapter closes with thought questions to ponder and explore with classmates, peers, and faculty. Again, the intention is to ensure that you are conversant—and, over time, fluent—in the language and tools of finance, economics, and politics. Chapters are augmented with quiz reviews that serve as checkpoints to help you assess your acquisition of this new knowledge. Qualified instructors may obtain access to ancillary materials, such as a sample syllabus, test bank, student supplements, and PowerPoints, by contacting textbook@springerpub.com.

**Summary and Conclusion**

The goal of *Health Care Financing, Economics, and Policy for Nurses: A Foundational Guide* is to help you understand health finance and economics, and powerfully incorporate this knowledge across a span that ranges from direct patient care to positions with national or even international impact. Without this understanding, nurses cannot find solid ground for leadership, and much of what is happening in the practice setting simply will not make sense. With it, nurses can change the world. Enjoy!
REFERENCES


ACKNOWLEDGMENTS

This book would not have been possible without a great deal of help and encouragement from others. Elizabeth Nieginski and Springer Publishing Company’s initial interest in the idea for this text, and their encouragement along the way, have been invaluable. William Patrick Rambur’s technical support and assistance in the development of ancillary materials was a saving grace. Thanks, son! Jill Mattuck Tarule’s conceptually elegant insights have created a more readable text, and her time and thoughtful edits are deeply appreciated. Two states, North Dakota and Vermont, have given me the opportunity to lead health reform within and beyond their borders. I am very grateful to the citizens of these states and my colleagues in these reform endeavors. You have taught me so much! And finally, special thanks to my friend with a cottage by the sea, whose love and support offered welcome refuge for a writer.
I

THE CONTEXT OF HEALTH CARE AND HEALTH CARE REFORM

Section I, comprising Chapters 1, 2, and 3, provides foundational background that is essential for you to be able to successfully navigate contemporary health care. Chapter 1 describes basics of health finance and economics, rather like an alphabet that is necessary for reading and writing in the health care landscape. Perhaps similar to first learning a new alphabet, it can be a bit tedious. Be patient. These terms and ideas are a language of power and influence that you will need to maximize your career opportunities.

Chapter 2 details the evolution of the U.S. health care system. Knowledge of this history is essential to understanding many contemporary issues, including health reform. This is because many reform elements are strategies to address unintended consequences of previous health care policies and accidents of history.

Chapter 3 pulls this information together to illustrate the ways payment reform—the way physicians, hospitals, home health care agencies, and other organizations are paid—shapes your daily work life and how you can use this knowledge to influence positive change. So, let us begin with Chapter 1 and sort out foundational concepts like financing, economics, and reimbursement, as well as become familiar with insurance-related aspects of the Affordable Care Act of 2010.
CHAPTER 1 PROVIDES an introduction to health economics and its influence on contemporary nursing and health care. Following completion of this chapter, you will be able to

- Define health economics and differentiate it from related concepts such as health financing and reimbursement
- Describe how health care is paid for in the United States
- Illustrate elements related to payment of health care services, such as third-party payers and commercial insurance
- Identify insurance-related elements of the Affordable Care Act (ACA)

1964: Mary Jane is excited to be in sixth grade. Her first day of school was magnificent! As her mother puts in the kitchen to make Mary Jane’s after-school snack, she settles in to read her history text. “America is the land of endless opportunity and unlimited natural resources,” announces the text’s opening statement. Reading these lines, Mary Jane smiles, thinking, “How wonderful it is to live in a world in which there are no limits!”
Nurses care about their patients. Some nurses, who like Mary Jane were imprinted with the myth of endless abundance, believe that there should be no limits on what is done for patients. Indeed, earlier generations of nurses, physicians, and other providers were socialized to believe that it is unethical to even consider the cost of care when making treatment decisions.

Contemporary nurses know better. They know that resources both within and beyond health care are not unlimited. They know that choices among alternatives will be, and need to be, made. What nurses often lack is the tools to help them think about ethical and practical ways in which scarce resources are managed, allocated, and used to maximize value and outcomes. This competency is an essential element of contemporary nursing practice, because the societal transition from a world of certainty and perceived abundance to one of multiplicity and perceived scarcity illustrated in the opening scenarios characterizes today’s health care delivery. Health care is too expensive, fragmented, and characterized by irregular quality. Unfortunately, many health professionals have been educated as if the world they will be working in is Mary Jane’s world of 1964.

Luckily, there is a whole discipline—complete with theories, research, and practical applications—that provides foundational nursing knowledge in the contemporary era of health reform. This discipline is economics. The overarching field of economics is concerned with the question of how goods and services are produced, organized, and delivered to maximize efficiency and value. The emphasis on value is important: Economics is not necessarily concerned with more, but better, a concern that nurses share as a fundamental value.

THEORETICAL ECONOMIC APPROACHES

There are different theoretical approaches to economics. One approach most nurses have been exposed to since elementary school is classic free market or
laissez-faire economics, which contends that less governmental intervention maximizes value. Conversely, Keynesian economics suggests a stronger role for government, particularly in times when the economy is strained. Both of these models assume rational, logical decision making. Newer models of economics question if human behavior is really altogether that logical and instead acknowledge the role of emotions in decision making. This approach is called behavioral economics. All of these orientations are useful to nurses. However, the economic conceptualization that is most useful to nursing care is health economics, yet another different approach that focuses on the unique aspects of health care markets.

Health Economics

Health economics is a relatively new discipline. It emerged as a distinct field following the 1963 publication of a manuscript by Nobel Prize–winning economist Kenneth Arrow titled Uncertainty and the Welfare Economics of Medical Care. Others built on Arrow’s seminal work and furthered understanding of the ways health economics shapes health care.

WHY STUDY HEALTH ECONOMICS?

The models and theories of health economics—and the research they have spawned—are useful to nurses. Like a mirror or guidepost, understanding health economics helps the nurse make sense of the often convoluted, paradoxical, and invisible yet pervasive ways economics shapes the organization, financing, and delivery of health care. Moreover, many of the policy decisions at institutional, state, and federal levels relate to economic incentives and how the money flows through the system. Thus, to serve patients and help shape a world in which the holistic, patient-/family-/community-centric vision of the profession of nursing can become a reality, nurses need a confident command of economic terms and ideas and to be able to apply them in the practice setting.

Yet for many of us nurses, the interpersonal aspect of the nursing role—taking care of people and building relationships—is precisely what drew us to the nursing profession in the first place. Economics, with complex mathematical formulas, nuanced theories, and interfaces with systems-level finances, can seem far removed from the working knowledge, concerns, and everyday work life of the nurse. Nevertheless, the field of economics and the profession of nursing share key interests.
WHAT SORT OF THINGS DO ECONOMISTS THINK ABOUT?

Some of the most pressing issues of economics are also issues nurses face every day. For example (adapted from Kernick, 2003):

- **What do we do when there is more need than resources with which to meet this need?**
- **From what perspective should these competing demands be viewed: that of individuals, society at large, businesses, or health professionals? Or is there a way that these can be considered simultaneously?**
- **What is value, and how do we maximize it?**
- **What is the influence of health care on health?**

This latter question is of particular importance to nurses as well as society at large, as it relates to social determinants of health such as educational level and socioeconomic class.

**SOCIAL DETERMINANTS OF HEALTH**

Although nearly 18 cents of every dollar spent in the United States goes to health care, health care contributes only marginally to health. As illustrated in Figure 1.1, there is a substantial misalignment between where the United States spends its health care dollar and what impacts health. Although medical care receives nearly 90% of national health expenditures, this care contributes only roughly 10% to health status. Conversely, healthy behaviors contribute roughly 50% but received a mere 4% of national health expenditures (Network for Excellence in Health Innovation, 2012). The best overall predictors of health status are factors such as socioeconomic class and educational attainment. So, in the aggregate, the most healthy among us are educated Americans in good jobs who live in safe neighborhoods. This creates a paradoxical tension; when more public and private money is put into health care, there are fewer resources available for job creation and education, which in turn, means a whole population may have fewer opportunities for the education, employment, and a lifestyle that is associated with better health. Thus, how money is distributed ultimately impacts the health of a population through social determinants of health (see Box 1.1 for the World Health Organization definition of social determinants of health). Health economics concerns itself with these issues because it considers and analyzes the manner in which scarce resources are allocated, for example, in light of alternative ways to allocate resources that impact determinants. It also considers how resource allocation impacts human behavior.
1. WHAT IS HEALTH ECONOMICS AND WHY IS IT IMPORTANT TO NURSES?

Figure 1.1
Spending for health determinants and health expenditures.
Adapted from Network for Excellence in Health Innovation (2012).

Box 1.1
What Are Social Determinants of Health?

The World Health Organization defines social determinants of health as follows:

Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and unavoidable differences in health status seen within and between countries.

Source: World Health Organization (WHO, n.d.)
HOW ECONOMICS DIFFERS FROM FINANCING AND REIMBURSEMENT

Financing: What Does it Mean?

Thus, economics, broadly defined, is concerned with the production, distribution, and consumption of services, and differs from financing, which refers to the obtaining of funds. Financial literacy is necessary to navigate daily life, and most nurses have a working knowledge of both of these concepts, despite not having identified them with these terms within their workplace or their professional knowledge. Here is an everyday example of the concept of financing. Please be careful to differentiate this concept from that of economics.

Justine has just completed college. Eager to rent an apartment, she checks the average monthly cost of housing and utilities in her region and estimates transportation and food costs. She realizes that she will need to clear at least $4,000/month if she lives alone, but with three roommates, that figure drops to $1,000/month. Justine decides that the latter is more feasible; she will need to find a way to finance $1,000/month.

As this general example illustrates, financing refers to how the resource comes to what is often called the agent—Justine in this example. In health care, the parallel to the agent to whom the resources are gathered is the payer, a concept that will be discussed shortly. Justine may have several options for financing her costs. She may find a job—certainly something most parents wish! She may instead ask for her parents to finance all or part of her monthly expenses. Or perhaps she is an heiress and can live off the interest of a trust fund. In any case, her expenses must first be financed. Note also that financing refers to how the money is obtained, but not what it is used for.

HOW IS HEALTH CARE FINANCED IN THE UNITED STATES?

The U.S. health care system also has several different mechanisms by which funds for health services are obtained. These U.S. health financing options include out-of-pocket money at the point of service from those who use health
1. WHAT IS HEALTH ECONOMICS AND WHY IS IT IMPORTANT TO NURSES?

care, taxes, and insurance premiums (see Figure 1.2). Each of these is discussed in greater detail, but for now it is important to simply distinguish the difference between health financing and health economics; health economics is a broad term that refers to overarching questions about the allocation of scarce resources, whereas financing is a narrower term that relates to how the money for services is generated in the first place.

Reimbursement: How Are Providers of Health Care Paid?

These two concepts, economics and financing, differ still from another key concept, reimbursement. Reimbursement refers to the money paid to providers of care for services delivered and is discussed later in this chapter as well as throughout this text. Financing refers to how the financial resources (money) for health services are raised, and reimbursement refers to what and how providers are paid for providing those services. You can think about this as money going into a bucket (financing) and money later being poured back out to pay for services used (reimbursement). Those providing reimbursement, that is, paying providers for the delivery of health services, are aptly called *payers*. As used in health care, the term *payers* includes *commercial insurance companies* and state and federal governments, termed *governmental*
payers, but not individuals paying out of pocket at the time of receiving a health care service. This is an important concept and is developed in more depth in the following section.

WHAT IS A PAYER?

Joey has just started a part-time job as he works on his BS in nursing. He is pleased to have a position in the billing department of University Hospital. There is a big learning curve, however, as he is confused about the different payers. The supervisor tells Joey that “payer mix” is very important to the hospital’s financial status. Just beginning to understand what a payer is, Joey now begins to wonder what “payer mix” means, what a good mix or a bad mix is, and how that is managed or controlled.

Although payers reimburse providers for the health care services they provide, the process is different than for other goods and services because the payer is an intermediary between the user of the services—the patient—and the provider of the service, such as the doctor, hospital, nurse practitioner, or home health agency. Although nurses provide services, typically the term provider references those who are reimbursed by a payer, such as doctors and hospitals. This rather odd situation is largely the result of the historical evolution of employer-based health insurance and is detailed in Chapter 2.

PAYER MIX

Payer mix refers to the combination of different payers any one provider may be reimbursed by and the proportion of each. Different financing mechanisms have funds bucketed into different payment vehicles, that is, different payers. These can be considered insurers, so let us look more carefully at what the term insurance coverage really means.

Insurance Coverage

COMMERCIAL INSURANCE

Commercial insurance is insurance that an individual or business can purchase. Common examples include state-level programs like Blue Cross and
1. WHAT IS HEALTH ECONOMICS AND WHY IS IT IMPORTANT TO NURSES?

Blue Shield and national companies like Aetna, to mention just two. In the United States, these commercial insurance companies can be nonprofit or for profit; for-profit companies have the expressed mission of returning financial dividends to stockholders in the company. Nonprofit companies also intend to make a profit, but these must be retained by the organization to support self-preservation, growth, or new initiatives. In the case of a nonprofit company, that extra revenue is termed a surplus rather than a profit. Unlike for-profit companies, nonprofit companies do not have shareholders.

GOVERNMENTAL OR TAX-FUNDED INSURANCE COVERAGE

Medicare and Medicaid are tax-funded insurance coverage programs. They are federal programs, but with many differences. Medicare is overseen at a national level, meaning states have little say in how Medicare operates within the state. Medicaid is a federal program administered at a state level. Both have specific inclusion criteria. Medicare is a system of insurance coverage for those older than 65, whereas Medicaid is a program for poor and some disabled individuals. Medicare is finance via a federal payroll tax, whereas Medicaid is a mix of state and federal taxes. Together, Medicare, Medicaid, and the Children’s Health Insurance Program (CHIPs) represented 22% of the federal budget, or $772 billion, in 2012. Nearly two-thirds of this was Medicare (Centers on Budget and Policy Priorities, 2014). Given these percentages, it is easy to see that our government is heavily involved in (a) financing health care and (b) playing a major role as payer. Thus, the next time you hear someone say “Government has no place in health care,” you can sagely respond, knowing that our government is deeply involved in U.S. health care as a financier through taxes and as a payer through Medicare, Medicaid, CHIPs, and TRICARE, the program for military dependents and military members using health care services not available through other means.

PAYER MIX AND COST SHIFTING

Each of these payers reimburses providers at different levels. Medicare theoretically reimburses at cost, whereas Medicaid reimburses below the cost of service provision. The numbers and proportions of individuals on Medicaid vary from state to state. This is because states have jurisdiction over the level of poverty at which an individual is eligible for Medicaid coverage. One state may start to cover individuals at 133% of poverty, for example, meaning that according to Federal Poverty Level (FPL) Guidelines, the person would need to make $1,293 or less to be eligible for Medicaid. Another state may be more
generous, allowing a person to make up to 300% of the FPL, or up to $2,918,1 and still be eligible for Medicaid benefits. This difference impacts the proportion of Medicaid-supported patients the delivery setting will see and treat. This proportion matters: No organization can consistently lose money, pay its employees (including nurses), and ultimately stay in business. If Medicare is a primary payer for a large number of patients in a given clinic, for example, that clinic may need to seek and treat a larger number of patients with commercial insurance, which pays at a higher rate than Medicaid and Medicare for the same services, and thus balance the clinic budget. It is also the reason payer mix is so important to any provider. A setting with more commercially insured patients and fewer Medicaid-insured patients will have a more robust financial situation than one with the obverse situation. This phenomenon of higher reimbursement from commercial insurance to offset the lower reimbursement from Medicare and Medicaid has the curious name of cost shifting, even though it is not cost that it shifts but charges. Understanding cost shifting can be very difficult for the lay public because it seems illogical that one payer would reimburse so differently than another for the exact same service. Because understanding cost shifting is so important to understanding commercial insurance rate hikes, it is discussed in more detail shortly. First, however, it is important to take a deeper dive into insurance and how it works.

Insurance or the Well Carry the Sick

Oscar is furious. He was hoping for a big raise this year, and things seemed on track. Now this! Big Company Human Resources just issued an announcement that the cost of health insurance is going up more than expected next year. Although a 2% across-the-board salary increase and a 3% merit pool had been anticipated, the increasing cost of commercial health insurance is going to eat away most of that 5% pool. Some employees may even see a resulting decrease in their take-home pay. Seething, Oscar mutters, “Those insurance companies are just so greedy.”

Tim is the CEO of Statewide Insurance Company. Reviewing the financials for the past year, he notes that there had been a dramatic increase in the use of health care by the employees in Big Company. Not only were more employees using health care, they were using very expensive health care. “I wonder if the employees realize that their use of health care in the previous year is a contributing factor to the rate hike this year.”
Perhaps because insurance costs are always on the rise, insurance companies often are on the receiving end of a great deal of negative public attention. Yet, in nonprofit insurance companies (“nonprofit” meaning those that are not designed to make profits to return to company shareholders), insurance premiums—the amount members pay each month to be insured—reflect health care use by the members, overhead to manage associated administrative costs, and a solvency pool or sort of safety net savings account in case there is an unexpectedly high number of claims. The latter are termed reserves.

Thus, insurance is a form of financial risk sharing, in which funds are redistributed from those who are not using health services to those who are (see Figure 1.3). In health care, the well carry the sick, with those who use

Figure 1.3
How insurance works.
few services financially covering much of the cost of services for those who use many. Typically, an individual does not know when or if he or she will need health services, and it is therefore an uncertain financial risk. By design, insurance spreads the financial risk out among the members of the insurance group.

A SIMPLE EXAMPLE TO ILLUSTRATE HOW INSURANCE WORKS

To illustrate, imagine two scenarios. In the first, you are uninsured. You are in a small accident, and the cost of your care is $1,000. You are responsible to pay the full $1,000 to those who treated you. These providers of health care may be hospitals, physicians, nurse practitioners, or others, such as physical therapists. In the second scenario, you again have an accident resulting in a $1,000 charge, but this time you are in an insurance group of 1,000 people. Now the risk is shared by everyone, and hypothetically each person’s contribution to your care is a mere one dollar. Health insurance, although a bit more complicated, works exactly like this in concept, except that the payment from each member of the group does not happen individually at the time of your accident. Instead, it happens in the form of a monthly premium, with the term premium referring to the amount each member pays to the insurance company each month. The insurance company then, in turn, doles out reimbursement for services to providers. If there is a great deal of use of health care services, or a few members are receiving a great deal of very high cost services, the insurance premium for the whole group will go up the next year. The insurance company uses the cost experience of the group to determine the likely amount of money needed in the next year. In short, insurance premiums mirror the underlying cost of care for individuals within the group insurance plan.

WHAT FACTORS IMPACT COST WITHIN A RISK-SHARING ARRANGEMENT?

The size and nature of the group that is sharing risk matters. In a large group, there are simply more people among whom risk may be spread. Again, by way of illustration, imagine a hypothetical group in which there were only three people. In this small group, there are not many people among whom the costs of care can be spread. Therefore, in general, a larger insurance group, such as employers with many workers, will be able to have lower monthly premiums, more covered services, or both because there are more people to spread out this uncertain risk.
The health status, age, and other aspects of members of the pool also impact the cost of care for individuals in the insurance group and so ultimately also impact the cost of their insurance premiums. This concept is familiar. Here are examples from automobile insurance:

Moira is glad to be alive! Driving through a rural area of Kentucky, her car suddenly skidded off the road into a tree. Although she was fine, her car was totaled. Three days later, although still relieved that she escaped unharmed, she ponders: “I wonder how much my insurance rates will go up.”

This is an example of what is called experience rating, where your individual history directly impacts the cost of your insurance. It can also impact you because you are a member of a high-risk group.

Moira’s 15-year-old son, Josh, has just received his driver’s permit. She is well aware that her insurance premium will go up when she puts Josh on her car insurance policy. Novice drivers have more accidents and, overall, young men have more accidents than young women. Josh, no matter how responsible he is, fits the profile of these high-risk, high-cost insurees. Moira knows that insuring Josh will bring a dramatic increase in her monthly premiums.

Experience rating is one approach to risk appraisal. The second is community rating. In experience rating, ill individuals pay higher premiums than well individuals. In community rating, ill groups pay higher premiums than well groups. Health insurance plans using experience rating will charge higher insurance costs for older, sicker individuals than for individuals who are younger and well. Similarly, individuals who are in high-risk occupations would have higher premiums. Unlike experience rating, community rating redistributes charges evenly throughout the group insured. Community rating charges all individuals in the same group the same premium cost, regardless of their age, gender, occupation, or other factors that impact health. Thus, cost increases for an individual reflect the group experience over the previous year.

Which is better: experience rating or community rating? Although on the surface it may seem logical that those who are well have less expensive premiums than those who are not, experience rating results in more expensive premiums for those who most need health care. Recall that the
foundational premise of health care insurance is that it redistributes funds by human need; community rating does this more consistently than experience rating (Bodenheimer & Grumbach, 2012). Community rating evens out the insurance charges throughout the group, meaning that some well people will have higher costs than they would in experience rating, as they are carrying the cost of others. At some point, however, it likely will be their turn, and others will carry the cost of their care. Some states have passed laws to assure that only community rating or modified community rating will be allowed within the state.

INSURANCE INDUSTRY CHANGES SINCE THE PASSAGE OF THE ACA

Of course, people prefer lower monthly premiums, so those insurance policies with lower premiums have a competitive advantage over those with higher premiums. One way a group’s health care insurance premiums can be kept low is to exclude those with known health conditions from the insurance pool. Prior to the passage of the ACA of 2010, sometimes referred to as Obamacare, two strategies of limiting cost of an insurance product were allowed. These were (a) preexisting health condition exclusions, meaning that if individuals have a health condition when they apply for insurance and that condition is judged to make them liable to need extensive and/or expensive health care, they may be excluded from an insurance group; and (b) limits on how much will be paid over a lifetime, called lifetime caps, which means there is a limit on the total amount one can receive for one’s health care. This can pose a real problem if a person is suddenly faced with a catastrophe with ongoing health consequences or if he or she has chronic conditions and reaches the cap. Although these strategies can keep a group’s insurance premium lower, it denies health insurance to those in greatest need of care, which violates the very rationale for insurance in the first place.

What the ACA Requires

The ACA has addressed these and other elements of the way health insurance has worked in the United States. This law requires insurance companies to remove the lifetime caps on the amount that can be paid for the care of an individual. It also ends the provisions that allowed insurance companies to deny insurance to an individual based on a preexisting health condition. This opens the opportunity for those previously uninsurable to be able to access health insurance. The ACA also allows adult children to stay on their
parent’s health insurance policy up to the age of 26, even when they are not dependents or in college. These provisions increase access to health insurance, but they do not decrease the overall cost.

HOW ELSE DOES HEALTH REFORM IMPACT FINANCIAL ACCESS TO HEALTH CARE?

The ACA of 2010 is a national health insurance program that requires all citizens to be covered by one or a combination of the forms of insurance coverage listed in Table 1.1 and thus is a hybrid financing model with multiple payers. Individuals who are not covered by Medicare or Medicaid are required to have commercial insurance. This requirement is termed a mandate. There are two types of mandates in the ACA, employer mandates and individual mandates.

**Employer Mandates**

Employers with more than 50 employees will be required to provide health care coverage for their employees or face a financial penalty. Originally planned to take effect in 2014, this part of the law was delayed until 2015 to allow employers more time to comply because those companies that were not paying for employee insurance, or not paying enough, now face a financing challenge to meet the new requirement.

### Table 1.1

<table>
<thead>
<tr>
<th>Financing Mechanism</th>
<th>Entity</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal payroll tax</td>
<td>Medicare</td>
<td>Federal government</td>
</tr>
<tr>
<td>Federal and state taxes</td>
<td>Medicaid</td>
<td>Federal program administered by state governments, within federal guidelines</td>
</tr>
<tr>
<td>Employees and employers</td>
<td>Private employer–based insurance</td>
<td>Private insurance companies (commercial insurance)</td>
</tr>
<tr>
<td>Individuals/families</td>
<td>Individually purchased insurance</td>
<td>Private insurance companies (commercial insurance)</td>
</tr>
<tr>
<td>Individuals/families</td>
<td>Individually purchased through health insurance exchanges</td>
<td>Private insurance companies (commercial insurance)</td>
</tr>
</tbody>
</table>
Individual Mandates

In addition to this employer mandate, that law includes an individual mandate under which an individual who does not have employer-based insurance, Medicare, or Medicaid is required to have insurance or, similar to the employer mandate, pay a penalty. The individual mandate survived a Supreme Court challenge to its constitutionality and remains the law of the land.

What About Individuals Who Cannot Afford to Comply With the Individual Mandate?

What about those who cannot afford to purchase health insurance? The ACA also has provisions for financial assistance to help those who cannot afford the cost of insurance. This form of financial assistance is called a subsidy. In addition, the law includes provisions that create the opportunity for individuals to better understand what they are buying when they purchase health insurance. To help individuals make the best choice for themselves, in terms of both cost and coverage, the law also includes the health insurance marketplace, typically referred to as health care exchanges. The exchange is actually a menu of options designed to enable individuals and small businesses to see what insurance packages are available and compare cost and other trade-offs. Despite the rocky rollout of the exchanges due to the complexities of the technological interfaces and demands, the overall concept behind the exchanges is very simple: comparison as a basis for choice.

WHAT DOES THE HEALTH CARE EXCHANGE DO?

Comparing health insurance plans can be confusing. Therefore, to be sure there are apples-to-apples comparisons, each plan must cover the same set of basic benefits. These basic, core benefits are termed essential health benefits (see Box 1.2). The essential health benefits also include some elements of prevention and screening that must be provided at no charge to the patient, meaning the financial disincentives to use these services have been removed (see Box 1.3). The definition of what services must be included is an important one; prior to this requirement, an individual may have purchased less expensive health insurance, only to find it was less expensive because it did not cover many services and left the person unexpectedly responsible for services he or she received.

What Is Different Among Plans in the Health Insurance Exchange?

What does differ among the options within the health care exchange is the balance between monthly premiums and associated cost sharing, that is, the
1. WHAT IS HEALTH ECONOMICS AND WHY IS IT IMPORTANT TO NURSES?

Box 1.2
Essential Health Benefits Required by the Affordable Care Act

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory patient services</td>
</tr>
<tr>
<td>Chronic disease management</td>
</tr>
<tr>
<td>Emergency services</td>
</tr>
<tr>
<td>Hospitalizations</td>
</tr>
<tr>
<td>Laboratory tests</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
</tr>
<tr>
<td>Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)</td>
</tr>
<tr>
<td>Pediatric services</td>
</tr>
<tr>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Preventive services (see Box 1.3)</td>
</tr>
<tr>
<td>Rehabilitative services and devices</td>
</tr>
</tbody>
</table>

*Source: HealthCare.gov (n.d).*

Box 1.3
Affordable Care Act—Required Preventative Services

- **Abdominal aortic aneurysm one-time screening** for men of specified ages who have ever smoked
- **Alcohol misuse screening and counseling**
- **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
- **Blood pressure screening** for all adults
- **Cholesterol screening** for adults of certain ages or at higher risk
- **Colorectal cancer screening** for adults over 50
- **Depression screening** for adults
- **Diabetes (type 2) screening** for adults with high blood pressure
- **Diet counseling** for adults at higher risk for chronic disease
- **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
- **Immunization vaccines** for adults—doses, recommended ages, and recommended populations vary

*Source: HealthCare.gov (n.d.)*
amount that a person enrolled in that plan would pay out of pocket. Lower monthly premium plans will have higher patient cost sharing at the time the patient uses health care services. Because of their name—Bronze, Silver, Gold, and Platinum—the different categories of essential health benefit plans within the exchange are sometime termed metals. These metals differ not in what services are covered, but rather in how individuals choose to balance the cost. Platinum, for example, has the highest monthly premium, but the lowest out-of-pocket expense when using services. Bronze has the lowest monthly premium of the metals, but the highest out-of-pocket expenses when using health services. There is even a term for the average proportion of health care that is paid for by the individual out of pocket. This term, actuarial value, is set at roughly 60%, 70%, 80%, and 90%, for bronze, silver, gold, and platinum, respectively. So, for example, a bronze plan pays for 60% of services used; platinum pays for 90%.

So, why would anyone choose a bronze plan? The trade-off is in the ongoing cost of the monthly premium, which is lowest in the bronze plan. Young persons who are betting they will not need health services may choose a bronze plan with the lowest monthly premiums, seeing that as a better value than paying higher monthly insurance premiums for care they do not expect to use. Conversely, persons with any chronic conditions may choose to pay more each month, the platinum plan, for example, because they know they use a lot of health care services and want the reassurance that 90% will be covered, especially if that is 90% of a very large health care bill. The subsidies—the difference between what a person’s expected contribution to insurance is and what he or she actually pays—are, by law, benchmarked to the silver.

**Are There Other Low-Cost Plans in the Exchange?**

There is one more category of health insurance plans in the exchanges required by the ACA. These are termed catastrophic plans. These plans also cover the essential health benefits to some degree, but differ from the bronze plans in that catastrophic plans do not cover 60% of the health care costs. Instead, they cover three primary care visits and certain preventative services and only cover additional services after the deductible of $6,350 for an individual plan or $12,700 for a family and thus typically would have an actuarial value of less than 60%. Federally funded tax credits and subsidies are not available for individuals covered by catastrophic plans, and participation is limited to those under 30 or those who cannot find coverage for less than 8% of their income.
WHERE CAN A NURSE DIRECT A PATIENT WHO ASKS QUESTIONS ABOUT HOW TO NAVIGATE THE COMPLEX TERRAIN OF HEALTH INSURANCE?

Nurses are well-trusted health professionals, and patient education across a range of issues is a core competency of nurses. That said, the decision of which plan to choose can have enormous consequences for a family; nurses who are asked advice on health insurance should be prepared with the general knowledge heretofore described, but may—understandably and appropriately—still feel at a loss to provide specific direction. Fortunately, navigators have been trained to help people find their way through the health insurance exchange. Nurses can feel confident about referring patients who ask questions about the exchange to these trained navigators. Take a moment to determine where navigators can be found in your region. Some states are also attempting to create user-friendly exchange websites in which individuals can include personal information like income to readily determine which plan would offer them the greatest financial or other advantage, including subsidies or tax credits. Unfortunately, simple-to-use sites can be complex to build, and at the time of this writing, some states are struggling to make their sites fully operational. Take a moment to review the health insurance exchange website in your state.

The ACA and Out-of-Pocket Maximums

For individuals choosing the bronze or silver plan or catastrophic coverage, the decision to keep money in their pocket each month may also be reinforced by another provision of the ACA that sets limits on the total amount of health care costs an individual or family will pay each year. This is termed out-of-pocket maximum or out-of-pocket limits, set at no more than $6,350 for individuals and $12,700 for a family (HealthCare.gov, 2014). Note that there were no out-of-pocket limits prior to the ACA, and—although for many families this is still a lot of money—a single hospitalization could far exceed this amount and would have fallen to the underinsured or uninsured family to pay prior to the required coverage in the ACA or would have been provided at a financial loss to the hospital as charity care or bad debt.

CONCLUSION

Health economics considers issues of value and efficiency, whereas financing considers how funds are gathered. One mechanism by which health care is financed is health insurance, and the ACA has built on the
existing employer-based insurance model to ensure insurance coverage for all Americans. There are many other provisions in the ACA. Yet, to move forward and understand the significance of each of these and what they mean to nurses and their patients, a firm understanding of the evolution of the U.S. health system is essential. As shown by the contrast between Will and Mary Jane in the opening scenarios, contemporary nurses face a complicated world. Many of the troubling elements of the current health care system are the result of the unintended consequences of the solutions adopted to address health system shortcomings. It is like an economic whack-a-mole game: One problem solved immediately creates another unsolved one. These unintended consequences are a driver of the evolution of the health care system to its present form. This is the focus of Chapter 2.

**Thought Questions**

1. What is health economics? How is it similar to and different from other branches of economics? How does it differ from health financing?

2. Who pays for health care in the United States? How?

3. What is the role of government in the financing of U.S. health care?

4. What elements of health care financing existed before the Affordable Care Act? What elements are new?

5. What is the best way to finance health care? Why?

6. What are the pros and cons of risk-rated insurance and community-rated insurance? Which is better and why?

7. Define the following key terms:
   - Actuarial value
   - Affordable Care Act of 2010
   - Behavioral economics
   - Catastrophic insurance
   - Classic free market
   - Commercial insurance
   - Community rating
   - Cost sharing
1. WHAT IS HEALTH ECONOMICS AND WHY IS IT IMPORTANT TO NURSES?

Employer mandates   Metal levels
Experience rating    Payer
Governmental payers  Payer mix
Health economics     Preexisting health condition
Health care financing Premium
Health insurance     Profit
marketplace          Reimbursement
Individual mandates  Reserves
Keynesian economics  Risk sharing
Laissez-faire economics Social determinants of health
Lifetime caps        Surplus

Exercises

1. You are asked to present to Nursing Grand Rounds. The organizers share that nurses seem to be confused about insurance-related aspects of the Affordable Care Act of 2010. Develop your talk to address these concerns.

2. Develop a short presentation to describe the health insurance exchange in your state.

Quiz

TRUE OR FALSE

1. In health care, financing and reimbursement refer to the same thing.

2. Health economics is a distinct branch in the field of economics.

3. The best overall predictor of health status of a population is access to health care.

4. Commercial insurance companies in the United States are always nonprofit organizations.
5. There is no difference in the amount of reimbursement providers receive from different payers.

6. In *experience rating*, insurance companies charge ill individuals more for health insurance than well individuals.

7. In health care, the *health insurance marketplace* and the *health care exchange* refer to the same thing.

8. The Affordable Care Act of 2010 allows individuals to stay on their parent’s health insurance until age 26, as long as they are dependents listed on a tax return or in college.

9. The Affordable Care Act of 2010 is sometimes called *Obamacare*.

10. The term for the minimal health benefits required by the Affordable Care Act is *essential health benefits*.

**MULTIPLE CHOICE**

11. In the United States, health care is financed via
   A. Taxes
   B. Insurance premiums
   C. Patients, as an out-of-pocket expense
   D. All of the above

12. Medicare
   A. Is a publicly financed health care coverage for most Americans 65 years and over
   B. Is financed through a combination of state and federal taxes
   C. Both A and B
   D. Neither A nor B

13. One insurance-related element of the Affordable Care Act of 2010 is
   A. The elimination of lifetime caps, the total amount an insurance company would pay any one individual for health care–related expenses
   B. Strengthening the preexisting exclusion clauses in health insurance, making it more difficult for individuals to obtain insurance
   C. Both A and B
   D. Neither A nor B
14. The health care financing plan of the Affordable Care Act includes
   A. Individual mandates
   B. Employer mandates
   C. Both A and B
   D. Neither A nor B

15. The term *actuarial value*
   A. Refers to the clinical value of a particular health care service or treatment
   B. Is eliminated in community-rated insurance
   C. Both A and B
   D. Neither A nor B

16. Individuals who are specially trained to help others understand health care insurance options in the health insurance exchange are called
   A. Brokers
   B. Navigators
   C. Actuaries
   D. Subsidizers

17. The term *payer mix* refers to the proportion of reimbursement a provider receives from commercial insurance, Medicare, and Medicaid. Payer mix is important because
   A. Organizations are reimbursed by Medicare at higher rates than the other payers
   B. It provides a financial incentive for providers to treat patients who are on Medicaid
   C. Both A and B
   D. Neither A nor B

18. The Affordable Care Act
   A. Sets what is termed *out-of-pocket limits* for individuals and families, limiting the total amount any one person or family would pay in health care costs in any one year
   B. Eliminates the cost shift
   C. Both A and B
   D. Neither A nor B

**NOTE**

1. 2014 FPL Guidelines for a family size of one.
REFERENCES


