Univerzita Karlova v Praze
Právnická fakulta

Veronika Černá

HEALTH CARE IN THE UNITED STATES OF AMERICA

(ZDRAVOTNÍ PÉČE VE SPOJENÝCH STÁTECH AMERICKÝCH)

Diplomová práce

Vedoucí diplomové práce: JUDr. Martin Štefko, Ph.D.

Katedra: Katedra pracovního práva a práva sociálního zabezpečení

Datum vypracování práce: srpen 2010 (rukopis uzavřen 25. srpna 2010)

Prohlášení

Prohlašuji, že jsem předkládanou diplomovou práci vypracovala samostatně za použití zdrojů a literatury v ní uvedených.

V Praze dne 25. srpna 2010 Veronika Černá

Poděkování

Děkuji JUDr. Martinu Štefkovi, PhD., vedoucímu mé diplomové práce, za cenné připomínky, účinnou pomoc při zpracování práce a ochotu při vedení práce.

Dále děkuji svým rodičům za to, že mi umožnili studovat a vždy mi byli oporou.

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INTRODUCTION

The United States of America, a federal constitutional republic comprising fifty states, is the third largest country in the world, both by the area (9.83 million km^2) and the population (over 309 million inhabitants).[1] Moreover, the U.S. economy is the world´s biggest economy and generates about a quarter of the world´s gross domestic product (GDP), i.e. the U.S. GDP is about $ 14.4 trillion. Approximately 16 % - 17 % of the U.S. GDP ($ 2.3 trillion) is spent every year on the nation´s health care, making it by far almost the most expensive in the entire world (only East Timor spends more on health care than the U.S.). [2] Even administration of health care system costs six times more per capita in the U.S. than in any Western Europe nation. [3] Despite the enormous expenses, the U.S. fails to achieve better health outcomes compared to other well developed countries (such as Australia, Canada, Germany), underperforms on almost every level of health care [4] and actually ranks as one of the only three industrialized OECD countries without universal health coverage (the other two being Mexico and Turkey).

How does the most controversial system of health care delivery and health insurance in the world works? Is it really completely free of government regulation? What is the relation between states and federal government in the health care industry? Why has the national health insurance for all citizens never been established? Who pays for private health insurance? What is Medicare and Medicaid? Does access to health care depend on people´s incomes? Why are some people uninsured? What is malpractice or health insurance fraud? Why is the U.S. health care so expensive? What is President Obama´s health care reform about? These are only few questions that cross our mind when one mentions the U.S. health care.

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[1] Central Intelligence Agency [online]. 2007 [cit. 2010-07-30]. United States. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/us.html>. ISSN 1553-8133.

[2] World Health Organization. World Health Statistics 2009 [online]. France : [s.n.], 2009 [cit. 2010-07-30]. Available at: <http://www.who.int/whosis/whostat/2009/en/index.html>. ISBN 9789241563819.

[3] TECSEC [online]. 2010 [cit. 2010-07-31]. Facts on Healthcare Costs. Available at: <http://www.tecsec.com/library/Healthcost.pdf>.

[4] DAVIS, Karen ; SCHOEN, Cathy; STREMIKIS, Kristof. Mirror, Mirror on the Wall : How the Performance of the U.S. Health Care System Compares Internationally 2010 Update [online]. New York, USA : [s.n.], June 2010 [cit. 2010-08-01]. Available at: <http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf>.

The thesis answers all of the questions above and many more. The U.S. health care system is often criticized as being too private, discriminatory in many ways and free of any regulation. We believe that nothing is black and white only. Without completely understanding the system, no one can make such assumptions fairly. Therefore, this paper provides a general description of the complex U.S. health care system and its major institutes to enable readers to gain some insight into the fundamentals upon which the whole system operates.

The thesis mainly focuses on health insurance system and health care law and regulation. It is irresoluble to provide the readers with exhaustive and comprehensive analysis of each and every institute of the system and remain within the limiting page scope of the thesis. However, we are convinced that the thesis manages to explore the core institutes that make the U.S. health care system so unique along with the key problems and helps anyone who is interested in knowing more about the system to understand it. Since this is a law school thesis, readers will also find information on the most significant acts and rules affecting the health care and health insurance; malpractice, antitrust and monopoly and health care fraud issues included.

The thesis consists of six chapters, ranging from basic overview of the system and brief history of the U.S. health care to largely debated health care reform of 2010. The biggest part is devoted to health insurance and health care law. While some may find certain chapters, such as history of the health care system, unnecessary, the opposite is true. The historical development of the U.S. health care system created the principles that make the current system differ from any other health care system in the world and elementary knowledge of that history is a must. In March of 2010, the health care reform was signed into law. A separate chapter thus portrays main provisions of one of the most significant pieces of the U.S. legislation. The health care reform chapter concludes the thesis with presenting major changes to come and affect the current health care system in the chronological order up to 2015. The conclusion presents several recommendations for the Czech health care system.

After having read the thesis, readers should be able to comprehend the operation of the U.S. system and subsequently make their own judgment about the effectiveness and fairness of the system. The thesis should also provide the background for formulations of possible recommendations for the Czech health care.

The incentive to write a thesis on the U.S. health care system comes from the lack of literature on similar topic in the Czech Republic. It is almost impossible to find comprehensive or even essential up to date literature addressed to functioning of the U.S. health care or health insurance system. While various issues of the U.S. health care system are being repeatedly brought up in the Czech press, such as the recent health care reform or the consequences of being uninsured, no or just little information on the system is provided. It is hard to form an opinion on certain issue without knowing the background first. As a result, the thesis contains more than one hundred and twenty electronic references that were imperative for obtaining crucial information about the system, mostly in the form of guides, reports or overviews by government agencies, various non-profit organizations and law schools. Hopefully, this thesis will be at least of little assistance to those longing for some basic insight into the U.S. health care.

All the information provided hereinafter is valid as of the August of 2010.

1. THE U.S. HEALTH CARE AND HEALTH INSURANCE SYSTEM

1. 1 Basic Facts

The U.S. currently does have neither national universal health care system nor national universal health insurance coverage. Actually, the U.S. is the only industrialized nation in the world that does not guarantee its citizens the right to access health care. [5] The U.S. Constitution is silent when it comes to the citizen´s right for health care. The main reason is that at the time the Constitution was passed no concept of health care existed. The U.S. Constitution establishes a system of federalism under which the federal government is granted a limited authority only and the remaining authority is left to the states. Therefore, should the federal government (even partially) control health care, the Constitution must provide such authorization (delegation). The 2010 health care reform, which basically gives Congress and the federal government the right to control and govern health insurance, is being challenged for its alleged unconstitutionality. The possibility of various interpretation of the "enumerated powers only" system of the U.S. Constitution provides the grounds for such allegation. [6]

The U.S. health care services are provided by both public and private entities and are paid for from both private and public funds. However, private funding largely prevails. [7] As a result, one of the main U.S. health care problems is the amount of people without health insurance who, in case of illness, must bear all the health care costs themselves and thus are very financially vulnerable to possible enormous health care costs if a health problem occurs.[8] According to the latest official data of the U.S.

[5] Connecticut Coalition for Universal Healthcare [online]. June 4, 1999 [cit. 2010-07-30]. The Case for Universal Health Care in the United States. Available at: <http://cthealth.server101.com/the_case_for_universal_health_care_in_the_united_states.htm>.

[6] BARNETT, Randy E. Is health-care reform constitutional?. The Washington Post [online]. March 21, 2010 [cit. 2010-07-30]. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/19/AR2010031901470.html>.

[7] Health care in the United States#Health care spending. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 8 August, 2004, last modified on 30 July, 2010 [cit. 2010-08-01]. Available at: <http://en.wikipedia.org/wiki/Health_care_in_the_United_States#Health_care_spending>.

Census Bureau, there were 46.3 million of uninsured Americans in 2008, which corresponds to about 15.4 % of the population. [9] Lowering and/or possibly eliminating uninsured population remains one of the main challenges and tasks for future health care regulations.

The U.S. health care reform, signed by President Barrack Obama in March 2010 and coming fully into effect in 2014, is expected, besides making the health care more accessible, to relieve the whole system of enormous costs. [10]

1. 2 Health Care Overview

The health care´s definition is "*the prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions*". [11] The U.S. medical system (and all health care systems in industrialized countries) is based on so called western medicine. The western medicine works to analytically identify the biomedical cause of health problems through various medical tests and then treat the problem area.

Health care may be divided into primary, secondary and tertiary. Primary health care means the care a patient receives at first contact with the health care system (usually at the general practitioner or family physician, general pediatrician, obstetrician and gynecologist), secondary care refers to a specific treatment by a primary care provider´s recommended specialist while tertiary care renders highly advanced and specialized treatments and services for specific illnesses, mostly in prestigious medical centers. [12]

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[8] Foreignborn.com [online]. 2000-2010 [cit. 2010-08-01]. Health Insurance Guide. Available at: <http://www.foreignborn.com/self-help/health_insurance/index.htm>.

[9] DENAVAS-WALT, Carmen; PROCTOR, Bernadette D.; SMITH, Jessica C. Income, Poverty and Health Insurance Coverage in the United States: 2008 [online]. Washington, Dc, USA : U.S. Government Printing Office, September 2009 [cit. 2010-08-01]. Available at: <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

[10] JOHNSON, Toni. Council on foreign relations [online]. March 23, 2010 [cit. 2010-08-02]. Healthcare Costs and U.S. Competitiveness. Available at: <http://www.cfr.org/publication/13325/healthcare_costs_and_us_competitiveness.html>.

[11] The Free Dictionary : The American Heritage® Dictionary of the English Language, Fourth Edition [online]. 2000, 2009 [cit. 2010-08-01]. Health Care. Available at:: <http://www.thefreedictionary.com/health+care>.

[12] The Free Dictionary : Dorland's Medical Dictionary for Health Consumers. [online]. 2007 [cit. 2010-08-03]. Care. Available at: < http://medical-dictionary.thefreedictionary.com/secondary+care/>

1. 2. 1 Health Care Providers

Health care provider is a term denoting medical professionals (e.g. a physician, a surgeon, a chiropractor, a nurse) and organizations providing services of health care professionals (e.g. hospitals). In the U.S., the health care industry consists of 595,800 establishments (institutions) providing some form of health care. These institutions vary greatly in size, staffing, organizational structures etc. Establishments range from small town private practices to large city hospitals. The following table shows the distribution of health care providers. [13]

Table 1.2.1.1: Percent Distribution of Establishments in Health Services by Industry Sectors in 2008

Industry segment	Establishments (%)
Total	**100.0**
Ambulatory healthcare services	**87.3**
Offices of physicians	36.0
Home healthcare services	3.7
Offices of dentists	20.4
Offices of other health practitioners	19.6
Outpatient care centers	3.6
Other ambulatory healthcare services	1.4
Medical and diagnostic laboratories	2.4
Hospitals	**1.3**
General medical and surgical hospitals	1.0
Other specialty hospitals	0.2
Psychiatric and substance abuse hospitals	0.1
Nursing and residential care facilities	**11.4**
Nursing care facilities	2.8
Community care facilities for the elderly	3.5
Residential mental health facilities	4.0

[13] United States Department of Labor : Career Guide to Industries [online]. 2010-11 Edition. 2 February, 2010 [cit. 2010-08-01]. Bureau of Labor Statistics. Available at: < http://www.bls.gov/oco/cg/cgs035.htm>.

Other residential care facilities	1.1

Source: United States Department of Labor : Career Guide to Industries [online]. 2010-11 Edition. 2 February, 2010 [cit. 2010-08-01]. Bureau of Labor Statistics. Available at: < http://www.bls.gov/oco/cg/cgs035.htm>.

Ambulatory health care services constitute more than 87 % of all health care institutions while hospitals only 1.3 %, indicating that the primary health care is widely accessible and prevailing. Primary health care is considered as the absolute basis of an effective modern health system. Thus, all key state health policies focus principally on strengthening the primary health care.

1. 2. 2 Health Care Characteristics

As mentioned above, the U.S. lacks the universal health care system, i.e. the system built around the universal coverage principle where every citizen has access to medical services if necessary. The universal health care system is funded either through taxes or through compulsory medical (or social) insurance paid by citizens, employers or a state itself if one cannot afford it. [14] Although the current U.S. system contains some significant universal coverage elements, it is everything but universal. All health care services are charged, i.e. fees apply for the provided health care. Unless people have subscribed health insurance or fall within the scope of government coverage, they are required to pay all of their health care costs themselves, out of their pockets. On the other hand, the public spending on public health insurance programs is higher in the U.S. than in most industrialized countries.

The common myth about the U.S. health care system is that it is completely privately run and free from any regulation. On the contrary, federal and state laws provide very strict rules in certain health related areas. [15] Especially with the recent health care reform efforts, further regulation is being proposed or enacted and most of the time has to withstand major amount of discontent and criticism from the people as too stringent and preventing the free market economy´s efficiency. But the criticism comes from the same people who complain of insufficient coverage of and poor access

[14] World Health Organization. Daily Living Conditions : Recommendations for Action, Part 3 [online]. [s.l.] : [s.n.], 2008 [cit. 2010-07-30]. Available at: <http://whqlibdoc.who.int/publications/2008/9789241563703_eng_part3.pdf>.

[15] Montreal Economic Institute . Two myths about the U.S. health care system. Economic Note : Health Series [online]. June 2005[cit. 2010-08-01]. Available at:: <http://www.iedm.org/main/main_en.php>.

to the present health care system. It is extremely hard to find a balance between private health care market and public efforts to improve the functioning of the free market to satisfy everyone.

The level of health care provided strictly depends on the type of health insurance plan. The proper medical care is denied to the uninsured unless they qualify for free charity type medical care/public medical program or in life threatening situations. The most common health insurance plans include inpatient and outpatient (ambulatory) routine, preventive and emergency hospital care and physician services, the more comprehensive ones (and also more expensive) offer extra prescription drug coverage or dental coverage. [16] The providers of health plans are subject to various, mainly state rules. However, the federal government has been recently adopting health care regulation as well.

Offices of physicians are almost always the first place a patient comes to with a certain health problem. Physicians practice privately or in joint practices in groups of practitioners with same or different specialties, mostly within primary care areas. Establishments of dentists function similarly, but tend more towards specific fields, such as orthodontics or cosmetic dentistry practices. Dental services are very expensive and majority of health insurance plans have only very limited dental coverage. Hospitals provide complete medical care from diagnostic services to complicated surgeries and continuous nursing care, both inpatient (overnight) and outpatient (ambulatory) based, and often specialize, thus offering higher level care. [17] Nevertheless, the patients must visit the primary care physician first in most cases for the insurer to pay for the higher level care in special medical centers and hospitals.

Health insurance coverage does come with various schemes of co-payments (i.e. fixed payment), co-insurances (i.e. percentage of actual costs) and deductibles; no deductibles/co-payments/co-insurance policy is very rare. Especially dental services deductibles are sky high. It is usually a good idea to purchase a supplementary dental coverage. Most federal government coverage programs also include nursing care (e.g.

[16] The Commonwealth Fund. International Profiles of Health Care Systems [online]. New York, USA : [s.n.], June 2010 [cit. 2010-08-01]. Available at:: <http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf>.

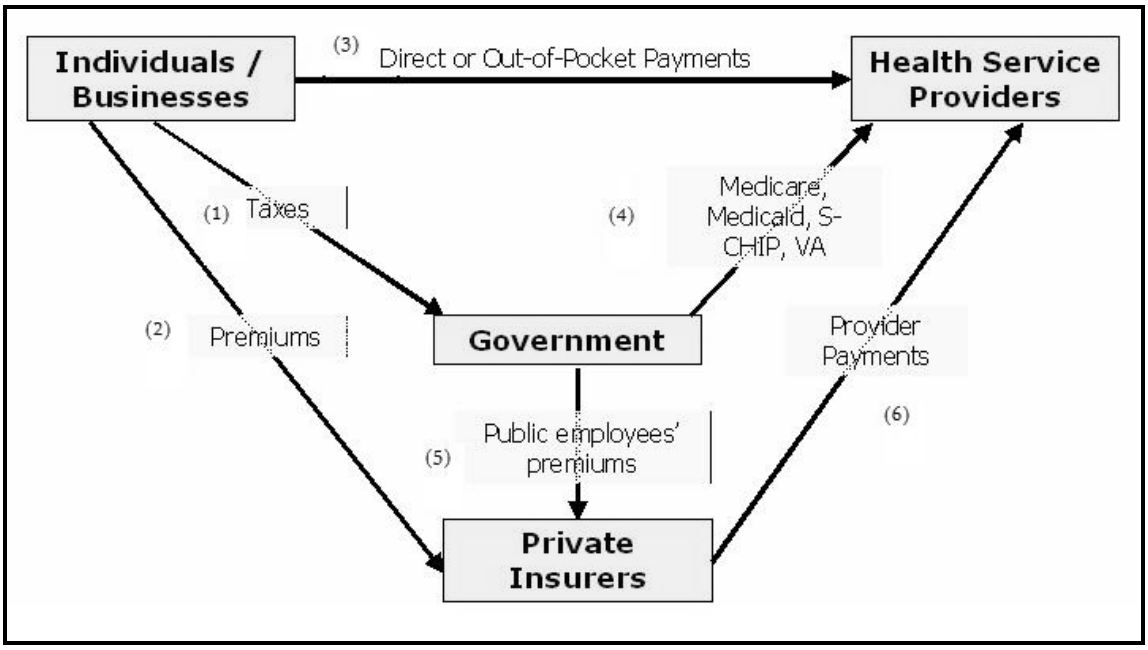
[17] United States Department of Labor : Career Guide to Industries [online]. 2010-11 Edition. 2 February, 2010 [cit. 2010-08-01]. Bureau of Labor Statistics. Available at: < http://www.bls.gov/oco/cg/cgs035.htm>.

hospice care, rehabilitation, health related personal care) and home health care (presence of skilled nursing staff at home, mainly for the elderly or terminally ill). [18]

1. 2. 3 Health Care Financing and Costs

Two streams of money are needed to finance the health care system: "money going in" to collect funds for health care and "money going out" to reimburse health care services. Both public (government) and private (private insurance companies) entities share the responsibility to finance the health care system. Altogether they are referred to as the "payers". Therefore, some literature describes the U.S. health care system as "multi-payer" as opposed to "single-payer", where for example only government finances the system (through taxes). [19] The following figure illustrates the mechanism of financing in the U.S. health care system.

Figure 1.2.3.1: Financing of the U.S. Health Care System



[18] The Commonwealth Fund. International Profiles of Health Care Systems [online]. New York, USA : [s.n.], June 2010 [cit. 2010-08-01]. Available at: <http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf>.

[19] CHUA, Kao-Ping. Overview of the U.S. Health Care System [online]. [s.l.] : [s.n.], February 10, 2006 [cit. 2010-07-31]. Available at: <http://www.amsa.org/AMSA/Libraries/Committee_Docs/HealthCareSystemOverview.sflb.ashx>.

Source: CHUA, Kao-Ping. Overview of the U.S. Health Care System [online]. [s.l.] : [s.n.], February 10, 2006 [cit. 2010-07-31]. Available at: <http://www.amsa.org/AMSA/Libraries/Committee_Docs/HealthCareSystemOverview.sflb.ashx>.

Individuals/Businesses:

(1) Both individuals and businesses pay income taxes to the government; employers and employees pay also separate Medicare tax used only to finance Medicare.

(2) Health insurance premiums are collected by private insurers. In respect of employees´ health plans, businesses bear almost all the costs while employees only participate in the remainder. Those who purchase health insurance individually must pay all the premiums themselves.

(3) Direct payments to health care providers are necessary if the individual lacks health insurance or if health coverage policy requires so (e.g. co-payments, co-insurances).

Government:

(4) The government uses tax revenues to reimburse health care providers for services rendered to patients enrolled in government health coverage programs.

(5) The government pays health insurance premiums for its employees, i.e. federal, state and other public employees.

The figure does not show major government cost - the tax exemption of employer-sponsored health insurance. Employers´ contributions to health insurance of their employees are completely tax deductible. Employees receive health insurance benefits as tax free compensation as well.

Private insurers:

(1) (2) (5) Private insurance companies collect premiums from individual, businesses and government.

(6) The collected premiums are used to reimburse the health care providers for taking care of patients with private insurance.

Health service providers:

(3) (4) (6) Health care providers provide medical care to individuals. They receive payments for their services from either the government or the private insurance companies.

About 85 % of people are covered by some form of health insurance (either private or government, i.e. public), leaving the remaining 15 % of the population uninsured. At the physician´s office, insured patients are generally responsible for some

portion of payment for the services, while their insurers bear the greater part of costs. Uninsured must pay all of the physician´s charges. To get the idea, on average, one routine doctor visit ranges from $ 60 to $ 265 in most parts of the U.S. If you do have some kind of private insurance, you will pay about 10 % of that cost. People without any insurance pay the whole cost and government programs policy holders have about 80 % discounts off the charges. [20] Hospital payments are organized in another way since there are for-profit, non-profit and public hospitals and each type of hospital manages the payments through one of a kind policies. The most common methods include per day charges, per service charges and per admission payments. [21]

The health system costs are one of the biggest concerns for the U.S. at present. The expenses are constantly rising but the health care´s quality and performance is nowhere near where it should be with the finances spent. The experts believe that without any immediate actions the expenses will keep advancing, reaching $ 3.1 trillion in 2012, $ 4.3 trillion in 2016; [22] and rising up to 21 % of the nation´s GDP in 2020. By the way, the current health care spending of $ 2.3 trillion is approximately 4.3 times the amount spent on national defense. In comparison, according to the OECD latest data (2008), Switzerland spends 10.7 % of the GDP on health care, Germany 10.5 %, Canada 10.4 %, Poland 7 %, Slovak Republic 7.8 % and the Czech Republic 7.1 % GDP. [23]

1. 2. 4 Successes and Problems of the U.S. Health Care

Even though the U.S. health care struggles in some areas and its system raises many concerns especially when thinking about the uninsured population, it still has many successes. The U.S. physicians are without questions one of the best in the world. They may be the most expensive as well, but the Americans that do have access to

[20] Please note that this is only average information, the actual cost-sharing mechanisms differ greatly among various health insurance plans.

[21] The Commonwealth Fund. International Profiles of Health Care Systems [online]. New York, USA : [s.n.], June 2010 [cit. 2010-08-01]. Available at: <http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf>.

[22] TECSEC [online]. 2010 [cit. 2010-07-31]. Facts on Healthcare Costs. Available at: <http://www.tecsec.com/library/Healthcost.pdf>.

[23] OECD [online]. June, 2010 [cit. 2010-08-04]. OECD Health Data 2010. Available at: <http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html>.

health care receive the best treatment possible, supported by modern equipment, advanced technology and state-of-the-art research facilities. On the other hand, key problems of the U.S. health care include, apart from health care spending and the existence of uninsured population, uneven distribution of health care services (as income, insurance and race have dramatic impact on person´s access to medical care), uneven quality of health services, lack of prevention, the fact that health services that are offered do not often meet the current demand (e.g. home health services for the elderly) and huge administrative waste due to complicated structure of health care financing. [24]

1. 3 Health Insurance Overview

The terms "health insurance" or "health care coverage" (the terms coverage and insurance may be used interchangeably) describe any program that helps pay for the medical expenses in the U.S. Health insurance exists in the form of privately purchased insurance or public insurance. [25] The insurance policies vary especially in limits for coverage, in the amount of deductibles and/or co-payments, in the availability of various treatments and in the existence of either the option of a policy holder to choose a physician freely or in the obligation to see the doctor recommended by the insurer.

The U.S. Census Bureau classifies the health insurance as private coverage and government coverage. We will work with the terms private and public health insurance or coverage. Private health insurance is either: (a) a group health plan, provided through an employer (otherwise known as an "employer-sponsored health plan") or a union or other group; or (b) an individual plan, purchased by an individual from a private company (referred to as a "private non-group health plan"). Public coverage is a health insurance plan financed from public sources (i.e. taxes) and includes medical programs known as Medicare, Medicaid, The Veteran´s Administration or simply VA, Military

[24] CHUA, Kao-Ping. Overview of the U.S. Health Care System [online]. [s.l.] : [s.n.], February 10, 2006 [cit. 2010-07-31]. Available at: <http://www.amsa.org/AMSA/Libraries/Committee_Docs/HealthCareSystemOverview.sflb.ashx>.

[25] Health insurance in the United States. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, January 21, 2008, last modified on July 26, 2010 [cit. 2010-07-30]. Available at: <http://en.wikipedia.org/wiki/Health_insurance_in_the_United_States>.

Health System and TRICARE, the (States) Children´s Health Insurance Plan or simply (S)CHIP, Native Americans insurance plans and individual states health plans. [26]

A selection of optional supplementary coverage policies completes the basic health insurance plans. Supplementary coverage policies include hospital indemnity insurance (a fixed payment is paid for each day spent in a hospital to cover for example babysitting expenses), dental insurance (almost none of the regular health plans cover dental expenses), vision care, specific disease insurance, accident insurance and many others. Most of the time, health insurance plans do not contain supplementary coverage and people must purchase it separately for an extra premium if they want to get a reimbursement for these services.

Apart from basic medical health insurance, insurance companies offer specific insurance plans associated with health care, such as "disability-income insurance" or "long-term care insurance". These insurance policies reimburse the loss of income due to inability to work (sickness, injury) rather than paying for the actual health service. [27]

In today´s recession, the number of people insured under private health plans decreases whereas the number of people insured under public health plans increases, indicating the income shifts related to the economic crisis. Out of 85 % of insured Americans, nearly 60 % obtain health insurance through employers and 9 % buy the private health insurance directly on the individual market. Government covers about one third of the population in public programs. About 15 % of Americans are uninsured. The numbers are not mutually exclusive as some people have more than one type of health insurance at the same time. [28]

The rising cost of health insurance is the primary reason that 15 % of people in the U.S. lack health insurance. A recent Harvard University study found that 50 % of all personal bankruptcy filings occurred at least partially due to medical debts. 25 % of the

[26] DENAVAS-WALT, Carmen; PROCTOR, Bernadette D.; SMITH, Jessica C. Income, Poverty and Health Insurance Coverage in the United States: 2008 [online]. Washington, Dc, USA : U.S. Government Printing Office, September 2009 [cit. 2010-08-01]. Available at: <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

[27] Health insurance in the United States. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, January 21, 2008, last modified on July 26, 2010 [cit. 2010-08-04]. Available at: <http://en.wikipedia.org/wiki/Health_insurance_in_the_United_States>.

[28] DENAVAS-WALT, Carmen; PROCTOR, Bernadette D.; SMITH, Jessica C. Income, Poverty and Health Insurance Coverage in the United States: 2008 [online]. Washington, Dc, USA : U.S. Government Printing Office, September 2009 [cit. 2010-08-01]. Available at: <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

U.S. people claim that their housing problems (e.g. inability to pay mortgage or rent) resulted from high medical expenses or debts. About 1.5 million families lose homes to foreclosure due to unpaid medical bills. [29]

We cover the main characteristics of the types of health insurance in the following chapters.

1. 4 History of the U.S. Health Care and Health Insurance [30] [31]

1. 4. 1 Origins of Modern Health Care and Health Insurance

Though the modern health care started to develop as late as the 1920s, the first health insurance plans were introduced around the 1850s. Franklin Health Assurance Company of Massachusetts offered first accident insurance that insured against injuries from railroads or steamboats accidents only. By 1866, almost sixty more companies presented similar accident insurance. However, it was not until 1890 that the first modern sickness coverage appeared. By the end of the 19th century, almost all insurance companies had some kind of insurance plan against disability and illness. The medical technology at that time was quite rudimentary and due to low spending on medical care people did not feel they needed health insurance. Instead, households were signing up for individual disability (sickness) insurance, which compensated the loss of wages due to sickness and inability to work. The first group employer-sponsored sickness insurance was issued in 1911.

Lack of health insurance demand was matched by unwillingness of insurance companies to offer private health coverage. The companies feared the moral hazard of insuring unknown commodity (health), adverse selection and thought they would not have been able to calculate the premium payments accordingly. The moral hazard basically means that as soon as people purchase health insurance, they do not avoid the potential risky behaviors anymore because they feel more protected by their health

[29] TECSEC [online]. 2010 [cit. 2010-07-31]. Facts on Healthcare Costs. Available at: <http://www.tecsec.com/library/Healthcost.pdf>.

[30] THOMASSON, Melissa. Health Insurance in the United States [online]. [s.l.] : EH.NetEncyclopedia, April 1, 2003 [cit. 2010-08-04]. Available at: <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

[31] NeuroSurgical.com [online]. 2009 [cit. 2010-08-04]. The History of Health Insurance In The United States. Available at: <http://www.neurosurgical.com/medical_history_and_ethics/history/history_of_health_insurance.htm>.

insurance policies. The adverse selection represents the situation where insurance companies fear that their clients will only be people with some serious health conditions, because the remaining, healthy population does not need to seek health insurance. Additional problems arose later on from the inability to properly define legal terms used in health insurance policies and contracts, such as the "loss of health".

Feeble interest in health insurance, as opposed to huge interest in sickness insurance, is said to be one of the main reasons why mandatory health insurance was not adopted in the 1920s in the U.S., whereas by that time, some European states already had some form of compulsory national health coverage. The American Association for Labor Legislation (AALL) proposed some mandatory health insurance legislation, but the states swept these plans aside. Neither ordinary people, nor physicians, nor insurance companies supported the AALL plans. People just did not care about the possible benefits of health coverage and physicians actually formed strong opposition. They were worrying about government regulating their fees and business. Insurance companies opposed as well, but for a different reason. The proposed legislation basically prohibited very popular commercial burial insurance, which covered funeral costs, and was sold by these companies. Furthermore, once the health insurance was in government hands, future interventions in the whole insurance business would soon follow. Logically, insurance companies needed to prevent that.

Health care prior to 1920 was very basic. Antiseptic methods were not yet established and most medical care including surgeries took place in patient´s homes. Come the 1920s, the illness and injuries treatment slowly shifted to hospitals as new technologies and methods were introduced. The quality of medicine rapidly grew which consequently increased the demand for health care services and caused the health care prices to boost. Physician care and quality improved as well. The number of medical schools dropped from 131 in 1910 to 81 in 1921 due to the standardization of requirements for medical license by the Council on Medical Education within the American Medical Association (AMA). Medical schools had to have better facilities and equipment in order to continue its existence. Entrance requirement were tightened. Tuition fees rose. The American College of Surgeons further restricted surgeons and hospitals by 1932. Eventually, all these restrictions and regulations led to additional rise of health care costs.

Before the development of health insurance, patients paid all health care costs themselves, literally out of their own pockets. This payment model is now known as the fee-for-service model. As the interest in hospital care increased, new payment methods were developed and health insurance policies were starting to appear.

1. 4. 2 Blue Cross and Blue Shield

In 1929, the first employer-sponsored hospital coverage plan was created. A group of Dallas teachers contracted with Baylor University Hospital to provide 21 days of hospitalization (room, board, medical care) for a fixed monthly payment of $ 6.00. The need for prepayment of hospital services grew during the Great Depression when the incomes of all dropped. Prepaid services ensured that the hospital bills would be paid and hospitals´ incomes were guaranteed. Large portion of hospitals was used to receiving endowments to help finance the health care. The endowments stopped due to Great Depression and prepayments were the only way to carry on the health services in hospitals. Soon, individual prepayment plans of each hospital generated competition between the hospitals. Hospitals then began to organize with each other to offer hospital coverage and to reduce the competition. This behavior eventually led to the establishment of Blue Cross non-profit organization in the 1930s.

Prepayment plans wanting to use the Blue Cross designation had to provide its clients with the free choice of physician and hospital. Single-hospital plans were thus eliminated since its clients did not have that choice. As Blue Cross plans were non-profit and in principal established in the society´s best interest, they benefited from the exemptions of regular tax and insurance legislation. Without the legislation exemptions, the plans would have had to organize as regular insurance stock companies (companies owned by stockholders entitled to company earnings) or mutual companies (cooperative organizations where the insured themselves own and control the company) and meet solvency requirements, be subject to assessment liability in the case of mutual companies (i.e. the owners must pay additional amount of assets to the company if insurance premiums fall short of insurance claims) and most importantly, pay the corporation taxes. Since the plans had only limited financial resources, they would have never been able to meet the requirements. The legislation enabled the plans not to create usual insurance reserve because the hospitals underwrote (i.e. secured) them. Hospitals even provided benefits to the plans´ clients when the plans did not have funds to

reimburse them. The health insurance market began to rise. Blue Cross was able to negotiate discount prices for health care with the hospitals due to promises of increase in the volume of patients and due to history of prompt payments.

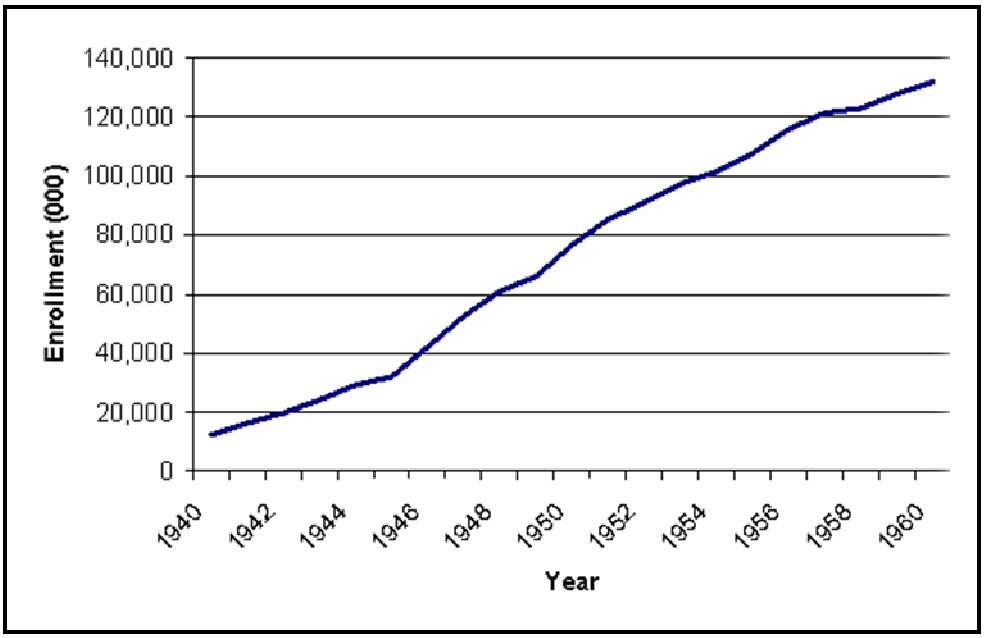
Physician services were not covered under Blue Cross plans. Physicians worried that if a third party had paid for the services, their incomes would have been much lower. However, in the 1930s the market development forced the physicians to prepay services themselves. Firstly, they feared that the hospitals would have eventually moved to provide physician services coverage themselves. Secondly, national health insurance was being heavily advocated as social insurance legislation commenced to emerge. Compulsory health insurance would limit the physician incomes far more than any, even the most comprehensive voluntary insurance, did. Physicians thus began to organize in similar way as hospitals before. The AMA, which created Blue Cross, came with ten guidelines for the physicians´ prepaid services in 1934. These guidelines ensured that only the physicians (and not hospitals) could supervise the health insurance for physician services. Similar legislation exemptions were granted and these plans functioned free from strict regular commercial insurance regulations. Physicians were represented on the board meetings of each plan. In 1939, the first prepayment plan for physician services was created by the California Physicians´ Service. The services were offered for the fee of $ 1.70 per month per employee. The AMA then encouraged other medical societies and groups to introduce their own plans. The plans later affiliated for the same reasons as hospital plans before and became known as Blue Shield plans as of 1946. Unlike Blue Cross plans, Blue Shield operated on a “mixed service-indemnity basis”. Physicians charged the insured patients the difference between their actual charges and the amount for which they were reimbursed by Blue Shield. Blue Cross, on the other hand, directly paid the hospitals the previously negotiated price for its services without the clients participating.

1. 4. 3 Commercial Health Insurance

Attracted to growing possibilities in the health insurance market after witnessing the success of Blue Cross and Blue Shield, commercial insurance companies finally entered the business, seeking profit. Medical technology was constantly advancing, making the health insurance policies sought after. Health insurance was starting to be viewed as an employee benefit and a form of compensation. The adverse selection that

the commercial companies used to fear was overcome by offering the health insurance only to the employed, and thus young and relatively healthy, population. From the 1940s and onwards, the health insurance was exploding in size and success. Figure 1.4.3.1 shows the gradually increasing enrolment in health insurance policies at that time.

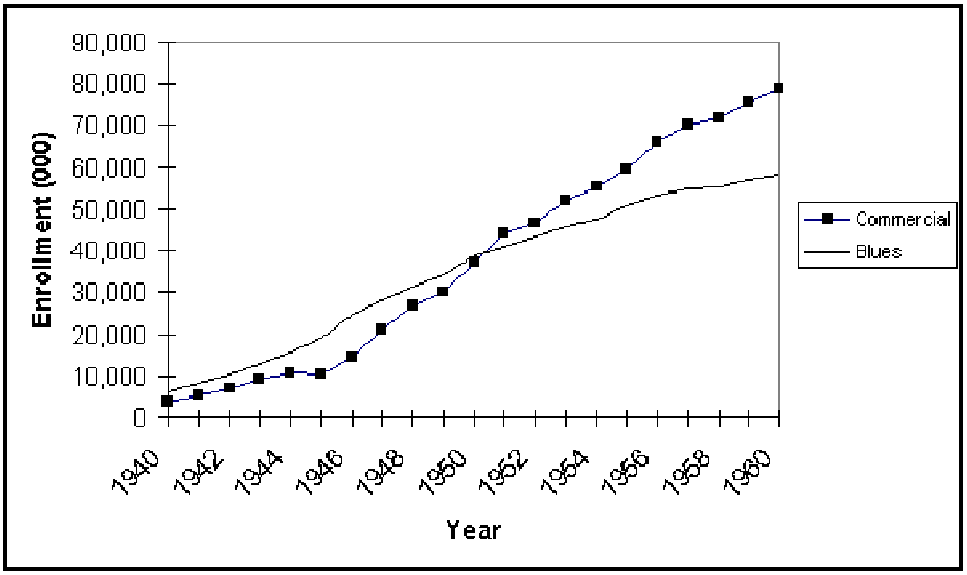
Figure 1.4.3.1: Number of Persons with Health Insurance from 1940 to 1960



Source: THOMASSON, Melissa. Health Insurance in the United States [online]. [s.l.] : EH.NetEncyclopedia, April 1, 2003 [cit. 2010-08-04].
Available at: <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

Blue Shield and Blue Cross soon found themselves in competition with commercial insurers. While Blue Shield/Blue Cross had to, as non-profit companies benefiting from a lot of regulation exemptions, charge all clients the same premium whether they were healthy or not (so called "community rate"), the commercial companies were "experience rating" their policies, i.e. requiring that people with more health problems pay higher premiums than the less sick people. Ultimately, the health insurance for healthier population was cheaper at the commercial insurance companies. Figure 1.4.3.2 illustrates the difference between the enrollment in commercial insurance and the enrollment in Blue Shield/Blue Cross insurance.

Figure 1.4.3.2: Enrolment in Commercial Insurance vs. Blue Cross/Blue Shield by 1960



Source: THOMASSON, Melissa. Health Insurance in the United States [online]. [s.l.] : EH.NetEncyclopedia, April 1, 2003 [cit. 2010-08-04].
Available at: <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

1. 4. 4 Government Interventions in Health Insurance

Health insurance as an employee benefit helped not only employees, but also employers. World War II resulted in scarce labor force on the market and government reacted by prohibiting using the increase of wages as a tool to compete for the potential employees. The 1942 Stabilization Act prevented the employers from raising wages without limits, but permitted offering health insurance as an additional benefit as a way for employers to attract the workforce. The employer based health insurance was not without regulation. The War Labor Board ruled in 1945 that the employers could not modify or cancel the group insurance plans within the contract period. In 1949, the National Labor Relations Board arbitrated in the *Inland Steel Co. v the United Steelworkers Union* that the term "wages" included pension and insurance benefits, thus enabling the unions to negotiate benefit packages for groups of employees as well within the wage bargaining. The case arose out of a union grievance for the Inland Steel Co.´s unilateral decision to order compulsory retirement at the age of 65 for its employees. The company refused to negotiate the pension scheme changes with the union because in the company´s opinion, the pension plans did not fall within the scope of collective bargaining. The union did not argue that the pension plans were subject to collective bargaining. Instead, it contended that the decision of the company to

unilaterally alter the provisions of pension agreement, which was part of the general collective labor contract that was within the scope of collective bargaining, was against the law. The Inland Steel Co. appealed, but the US Court of Appeal affirmed this ruling in *Inland Steel Co. v the National Labor Relations Board* and held that the pension plans are subject to mandatory collective bargaining. The Inland Steel decision established a legal framework within which no employer can install, alter or terminate pension plan during the term of an applicable labor contract without the assent of a union. [32]

Employer-based health insurance plans had strong government support, especially in tax area. Onwards 1954, employers were not required to pay payroll taxes on their contributions to employees´ health plans. At the same time, the employer´s contribution to employees´ health insurance was exempt under certain circumstances from the employees´ income taxes as well. For an explanation, payroll taxes are the state and federal taxes that an employer must withhold or pay on behalf of its employees, also known as employment taxes. Businesses also pay other kinds of taxes, but payroll taxes only refer to part of taxes associated with having employees.[33] [34] The Internal Revenue Code (IRC) contained (and still does contain) all legislation for health insurance tax exemptions.

1. 4. 5 Medicare and Medicaid

By the 1960s, the health insurance system in the U.S. flourished. Nearly 75 % of Americans had health coverage in some form. Ironically, the successful implementation of voluntary private health insurance system prevented the establishment of national health care system and national health insurance. The U.S. opposed the socialistic health care systems because it feared it would have compromised the doctor-patient

[32] KYLE N. BROWN, Dan Mays McGill, et al. Fundamentals of Private Pensions [online]. eight edition. [s.l.] : Oxford University Press, 2005 [cit. 2010-08-04]. Available at: <http://www.google.com/search?q=fundamentals+of+private+pensions&tbs=bks%3A1&tbo=1&hl=cs>. ISBN 0-19-926950-5.

[33] Generally, in respect of payroll taxes, each employer must withhold, deposit, report and pay income tax, social security tax, Medicare tax and Federal unemployment tax (FUTA). These taxes are withheld from the employees´ salaries with the exception of FUTA. FUTA is the only payroll tax paid completely from the employer´s funds without any contribution from the employees.

[34] U.S. Department of the Treasury. Employer´s Tax Guide : For use in 2010 [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-01]. Available at: <http://www.irs.gov/pub/irs-pdf/p15.pdf>.

relationship and distorted the market. The AMA was the main player in defeating any proposals for nationalized health insurance and even turned down completely the Murray-Wagner-Dingell bill, which aimed to implement comprehensive mandatory health insurance for all Americans.

First signs of acceptance of the possibility of compulsory health insurance existence came with the idea to offer health insurance to persons over 65 years of age. The critics of the nationalized health insurance could not argue that aged citizens were among the most medically needy in the society. The elderly did neither qualify for the employment health plans since they were not employed, nor did have the income to afford commercial health insurance. In 1965, Medicare was created by President Lyndon Johnson´s administration. At that time, Medicare was a federal program of two parts. Part A introduced the mandatory hospital coverage program in which the aged automatically enrolled when they reached the age of 65. Part B provided supplementary medical insurance for physician services. Medicare was financed through combination of income taxes, payroll taxes, trust fund interests and premiums paid for supplementary Medicare physician insurance. The legislators reimbursed physicians according to their "usual, customary and reasonable rate". Sadly, physicians continued to "price discriminate" the patients and billed the patients more than Medicare paid, thus forcing the patients to pay the difference themselves. Still, by 1966, Medicare provided health insurance for more than 19 million people that would, without its existence, be left uninsured.

In an effort to help other groups of disadvantaged population, Medicaid was enacted as a means-tested federal-state program to provide medical care for the poor on social welfare. The federal government only specified minimum standards for Medicaid as opposed to complete regulation of Medicare. Medicare ensures uniform benefits and standards in every state whilst Medicaid moves in between the guidelines set by the federal government. Hence, each state is free to establish different eligibility requirements and provide different benefits for Medicaid, as long as it acts within the federal framework. In 1966, there were about 10 million recipients of Medicaid-funded health care.

1. 4. 6 Recent Development

The expenditures on federal health coverage programs, Medicaid and Medicare, rose dramatically in the late 1960s. Major changes in reimbursements took place in 1983. The government´s reimbursements started to be based on the diagnosis instead of on the individual physicians´ fees in order to limit the overall health care expenditures. In the late 1980s and 1990s, health care costs were growing again. As a reaction, majority of employers exchanged the fee-for-service plans for less expensive "managed care plans" to avoid costs. Other efforts to further improve health care system and its financing followed. For example, the U.S. President Bill Clinton proposed a health care reform in 1993 that was supposed to guarantee health insurance for all citizens. The reform was never enacted due to Congress´s concern about its expensiveness. Series of alternative proposals were presented, but none of them passed. In 1996, the Mental Health Parity Act was passed. Since then, employers have had to include psychiatric benefits in their health plans. Before adopting the Mental Health Parity Act, mental health services were rarely covered by health insurance policies. Congress also passed the Health Insurance Portability and Accountability Act in 1996 (HIPAA), which has been protecting individuals from losing health insurance when they moved from one job to another. However, the HIPAA does not regulate the comprehensiveness of insurance provided by employers in any way. Several other acts were passed without majorly changing the nature of the system, e.g. the Medicare Modernization Act of 2003 or the Patient Safety and Quality Improvement Act of 2005. The President Bush´s administration promised to reform health care as well, but the concern for the state of health care faded away when the terrorist attacks occurred and recession and economic crisis started, sweeping the health care reform debates aside, as, according to the government, more urgent issues came up at that time. Finally, President Barrack Obama gathered necessary support to pass the Patient Protection and Affordable Care Act as the basis for complete health care reform in 2010.

2. HEALTH CARE LAW

2. 1 Introduction to the U.S. Law and Legal System [35]

The U.S. legal system consists of several levels. This is imputable to the thirteen original founding U.S. colonies declaring their independence from the British crown and having the Declaration of Independence pronounce them "free and independent states". Therefore, the states have remained separated from the federal government. The U.S. Constitution, adopted in 1787 and ratified in 1788, fixed boundaries between federal and state law and basically created the federal government. It also divided federal power among other branches of government, thus constituting "separation of powers" and system of "checks and balances" to prevent any branch from overwhelming the others. Moreover, the Constitution delineated the forms of law that Congress (i.e. the federal government) may pass.

Not only statutes form the U.S. federal law. Congress has the power to authorize administrative agencies to further regulate the matter by adopting various rules within the statutory boundaries. Furthermore, English common law principles are part of the law as well. The Constitution and statutory law supersede common law in most areas. However, the courts continue to apply these principles in order to fill in the legal gaps if necessary.

The main idea of the functioning of the U.S. law is expressed in Article IV of the Constitution: "*This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding*". Simply said, where the Constitution speaks, no state may contradict it. As can be expected, the Americans still struggle with the precise delimitation of powers between federal and state levels. The contingent lack of power to regulate certain area for either federal or state agencies is often the base of claims alleging the Constitution breach at the U.S. Supreme Court.

[35] U.S. Department of State. Outline of the U.S. legal system [online]. [s.l.] : [s.n.], 2004 [cit. 2010-07-31]. Available at: <http://www.america.gov/media/pdf/books/legalotln.pdf#popup>.

Other sources of law (apart from the Constitution, acts of Congress and administrative regulations) include various forms of state law and common law. [36] Common law continues to develop and plays an important role in state court systems as individual states often intentionally do not regulate the areas for which there exists some "common law regulation". Judicial precedents rank among the most used forms of law and unlike in the Czech Republic, the individual rulings of higher courts are most of the time legally binding for lower courts.

State laws work upon this principle: "*The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the People*". [37] However, the federal government has the power to restrict the actions of states under the 14th Amendment of the U.S. Constitution: "*No State shall...deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.*" Especially the "equal protection" clause greatly expanded powers of federal government to limit the states in their legislation (e.g. *Brown v Board of Education*, 1954 [38]). Even with the enhancing powers of the federal government, most areas still remain within states´ discretion. Yet, the recent health care reform has started the debate on expanding federal powers once again.

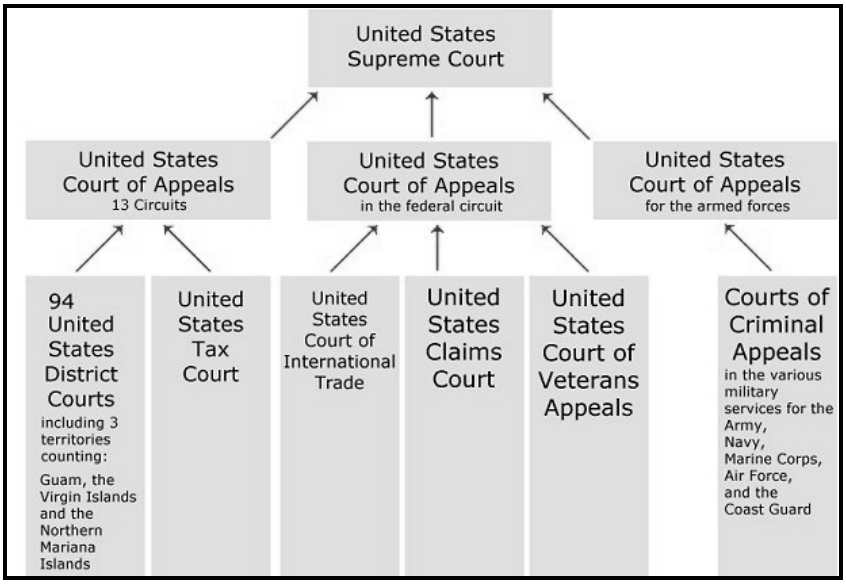
We provide two basic graphs of court systems only to get a general idea of the complexity of the U.S. legal (court) system, since this topic is not within the scope of the thesis. Figure 2.1.1 shows the structure of the U.S. federal court system, while Figure 2.1.2 demonstrates one of many alternatives of possible structure of state court system (existing along the federal court system).

[36] collection of customs, judicial decisions and principles from traditional England

[37] the U.S. Constitution, 10th amendment

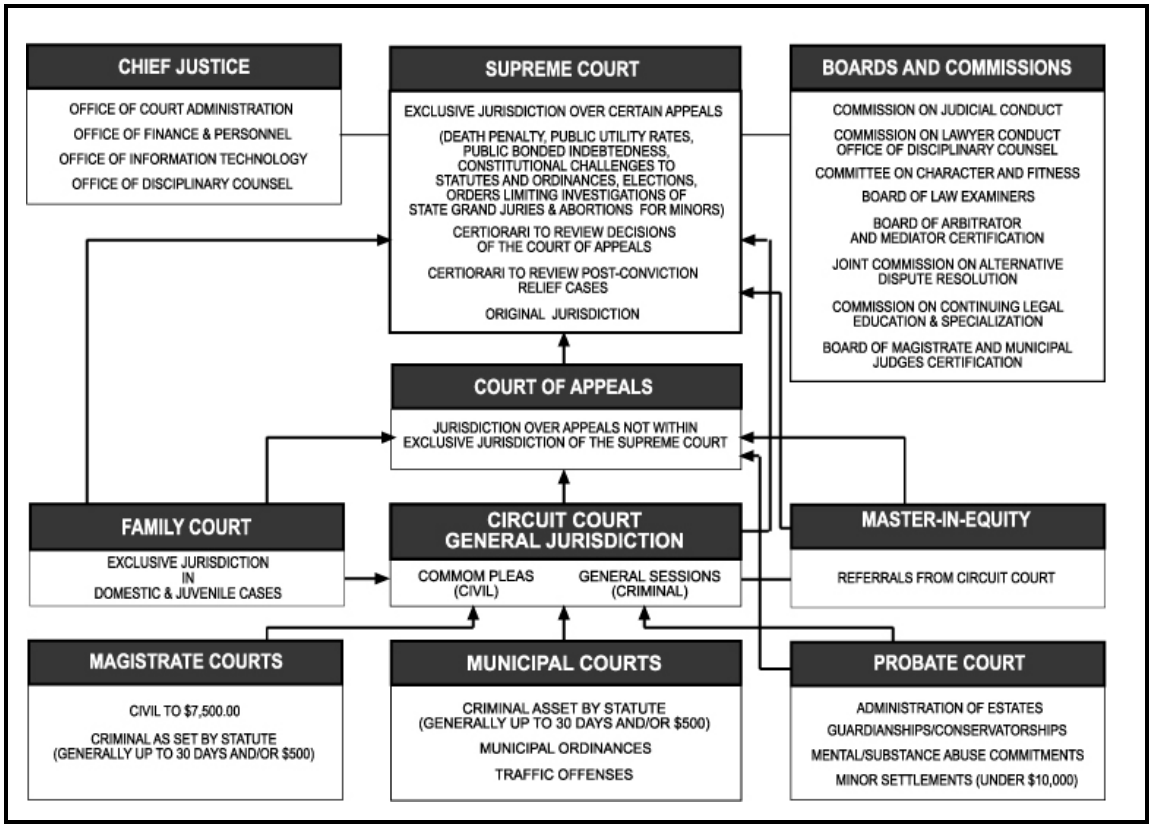
[38] segregation in public schools violates the equal protection clause of the 14th amendment

Figure 2.1.1: The U.S. Federal Court System



Source: U.S. Department of Justice : United States Attorneys Kids Page [online]. 2010 [cit. 2010-08-01]. CHART DEPICTING THE APPEALS PROCESS FOR THE U.S. SUPREME COURT.
Available at: <http://www.justice.gov/usao/eousa/kidspage/appealchart.html>.

Figure 2.1.2: South Carolina´s State Court System



Source: South Carolina Judicial Department [online]. 2000-2010 [cit. 2010-08-01]. The South Carolina Judicial System.
Available at: <http://www.judicial.state.sc.us/summaryCourtBenchBook/HTML/GeneralA.htm>.

Each of federal government branches: legislative, judicial and executive, exercises some powers in the legal system. Within legislative branch, the Constitution deputes the power to pass legislation to Congress. A proposal considered by Congress is a "bill". If a majority of each house of Congress [39] (or two thirds if the procedure repeats after the President´s veto) vote to adopt a bill, a bill becomes law. Federal laws are called "statutes". The powers of Congress are limited by the Constitution since the Constitution specifies precisely the areas where Congress may or may not legislate. For example, Congress is prohibited from levying taxes on export or from passing retroactive laws. Unfortunately, some delegations are very vague (i.e. "to regulate commerce with foreign nations") and need to be further interpreted.

The U.S. federal judiciary deals with cases involving federal law and with disputes between citizens from different states. The U.S. Supreme Court also determines whether a particular statute or law has violated the Constitution (i.e. the rights guaranteed to the people thereby); and if it has, the Supreme Court declares the law invalid. The power to determine the constitutionality of statutes was established in *Marbury v Madison* case in 1803. One of the problematic areas concerning the jurisdiction is the "commerce clause" [40] of the U.S. Constitution, allowing the federal government to regulate commerce with foreign nations, among several states or with the Indian Tribes. Congress has been stretching this concept, with the encouraging interpretation of the Supreme Court, to a surprising level. The Supreme Court numerously affirmed the power of Congress to regulate such areas where the affect on interstate commerce was none or minimum at most. The vague Supreme Court interpretation of all the powers of federal government has been a problem of the last decade. However, the commerce clause debate is never-ending and even now legal disputes arise out of it (e.g. the 2010 health care reform constitutionality).

The executive branch consists of the President and several Departments (similar to Ministries), each housing a number of agencies and bureaus. All departments are accountable to the President. The complex relationship between the three branches is not as simple as it used to be with the growing number of inter-branch delegations. Nowadays, if a government agency is granted the power to regulate some area by

[39] the House of Representatives and the Senate

[40] Article I, Section 8, Clause 3 of the U.S. Constitution

Congress, e.g. food chemicals, it may become responsible, depending on the level of delegation, to even assess penalties (fines) for breach of its regulation, although the assessment of penalties used to be the exclusive power of judicial branch before. The Administrative Procedure Act needs to be followed by the agencies acting in delegation and if the delegated powers exceed some level, courts will withdraw the delegation and invalidate the statute that gives the agencies the particular power. [41]

The Office of the Federal Register publishes the collection of all laws and resolutions enacted during each session of Congress [42] in the "United States Statutes at Large" (similar to the Collection of Statutes of the Czech Republic). The Statutes at Large contain every public and private law passed by Congress chronologically, in order of the date it was enacted into law. The printed Statutes at Large function as official legal evidence of the contained laws. [43]

Figure 2.1.3: A few volumes of the United States Statutes at Large

Source: File:Unitedstatesstatutesatlarge.jpg. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 15 March 2009, last modified on 15 March 2009 [cit. 2010-08-01]. Available at: <http://en.wikipedia.org/wiki/File:Unitedstatesstatutesatlarge.jpg>.

Another source of federal law is the "United States Code" or simply the "USC". The USC codifies the law by the subject matter based on what is printed in Statutes at Large and is divided into 50 alphabetically sorted Titles (e.g. Bankruptcy, Commerce

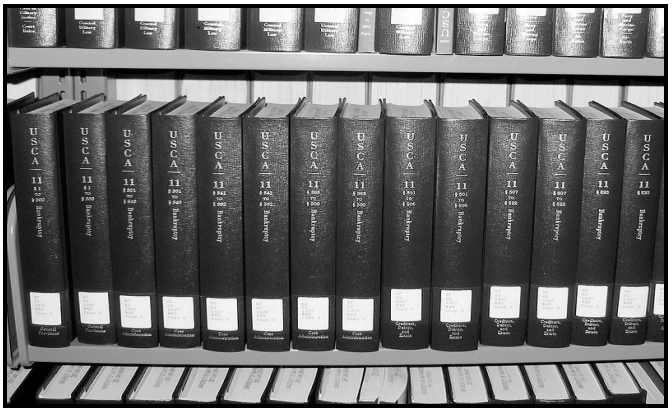
[41] this is similar concept as in the European Administrative Law

[42] concurrent resolutions, proclamations by the President, proposed and ratified amendments to the Constitution and reorganization plans are also included in the Statutes at Large

[43] GPO Access : The U.S. Government Printing Office [online]. 2008 [cit. 2010-07-31]. Statutes at Large: About . Available at: <http://www.gpoaccess.gov/statutes/about.html>.

and Trade, Copyrights, Crimes, Hospitals, Indians, Public Health, Tax etc.). The USC is published every six years by the Office of the Law Revision Counsel of the U.S. House of Representatives and each year annual cumulative supplements are published to bring in any new legal information. However, the USC does not contain regulations issued by the agencies of the executive branch [44], decisions of the Federal courts, treaties and laws enacted by states or local governments. [45]

Figure 2.1.4: A Few Volumes of Title 11 (Bankruptcy) of the United States Code



Source: File:Uscatitle11.jpg. In *Wikipedia : the free encyclopedia* [online]. St. Petersburg (Florida) : Wikipedia Foundation, 15 March 2009, last modified on 15 March 2009 [cit. 2010-08-02]. Available at: <http://en.wikipedia.org/wiki/File:Uscatitle11.jpg>.

The Statutes at Large and the USC exist alongside each other because of the different approaches towards compilation. Once enacted into law, a statute is published in the Statutes at Large in the previously described manner and simultaneously adds, modifies or deletes some part of the USC. Therefore, a single act, for example bill providing relief for family farms, will appear only in one place in the Statutes at Large, but will be present in more titles of the USC, e.g. in Titles called Tax, Public Lands and Agriculture. The authority for the law published in the USC comes from its enactment though the legislative process and not from its presentation in the USC. The USC revising authority continues the process of compiling statutory law in codified from even after the publishing of the USC. Once a particular Title is complete (all the relevant law is compiled to the Title), Congress is asked to enact that Title as "positive

[44] these exist either in the "Code of Federal Regulations" or in the "Federal Register"

[45] GPO Access : The U.S. Government Printing Office [online]. 2010 [cit. 2010-08-04]. United States Code: About. Available at: <http://www.gpoaccess.gov/uscode/about.html>.

law", meaning that Congress makes the Title itself, along with its content, an act of Congress. If that happens, the respective Title repeals all previous enactments on the subject, even the ones already published in the Statutes at Large, and is made into legal evidence of the law in force. All remaining Titles are only "prima facie evidence" [46]. Yet, the USC is very accurate and the difference between enacted and not enacted Titles is mostly academic. Not even the Supreme Court cross references the law contained in the USC to the Statutes at Large and assumes legal evidence of all the law presented in the Titles. Until now, 23 Titles have been enacted into positive statutory law. [47]

For the health care regulation, two Titles are particularly important: Title 24: Hospitals and Title 42: Public Health and Welfare.[48]

2. 2 Health (Care) Law and Medical Law Issues

The health care industry is the largest and most heavily regulated sector of the U.S. economy, accounting for annual expenditures of $ 2.3 trillion. Health care generates, due to its complexity and size, countless numbers of legal issues and disputes arising thereof. [49] Preserving public health is a primary duty of the state. Therefore, majority of health regulation is adopted at the state level. However, the federal regulation increases when the legal problems associated with a specific area of health care or health care law occur in more than one state. Many states delegate the authority to regulate concrete health care areas to state departments of health and/or other governmental agencies.

Federal health law is associated with the activities of the Department of Health and Human Services (HHS), which administers majority of health related programs, such as financial assistance to the indigent, conducting research, providing health care services or enforcing federal health laws. The HHS also supervises Medicare and Medicaid health insurance programs. Other health related federal agencies include:

[46] a rebuttable presumption, i.e. such evidence is deemed proved unless rebutted

[47] United States Code. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 25 February 2002, last modified on 27 July 2010 [cit. 2010-08-01].
Available at: <http://en.wikipedia.org/wiki/United_States_Code>.

[48] Title 42 contains statutes governing key federal programs such as Social Security or public health insurance

[49] Cadwalader, Wickersham & Taft LLP. FindLaw : For legal professionals [online]. 1998 [cit. 2010-08-04]. An Overview of the Health Law Specialty. Available at: <http://library.findlaw.com/1998/Jul/1/126786.html>.

- Administration for Children and Families
- Agency for Toxic Substances and Disease Registry
- Center for Disease Control (CDC)
- Center for Food Safety and Applied Nutrition
- Department of Health and Human Services (HHS)
- Food and Drug Administration (FDA)
- Frederick Cancer Research & Development Center (NCI/FCRDC)
- National Cancer Institute
- National Center for Health Statistics
- National Institute of Environmental Health Sciences
- National Institute of General Medical Sciences
- National Institute on Drug Abuse (NIDA)
- National Institute of Health (NIH)
- National Library of Medicine (NLM)
- National Toxicology Program
- NLM Health Services/Technology Assessment Text
- Occupational Safety and Health Administration (OSHA)
- Office of Disease Prevention and Health Promotion (ODPHP)
- Office of Environment, Safety, and Health (Department of Energy)
- Office of Human Radiation Experiments (Department of Energy)
- Social Security Administration
- Substance Abuse and Mental Health Services Administration (SAMHSA) etc.

It is obvious from the number of executive agencies operating in health care that there is an emerging pattern of judicial, legislative and even executive control over medical practice and medical matters. [50] Since majority of health related agencies has been granted the power to adopt regulations themselves, the health law system is not exactly transparent.

Health law, health care law and medical law are each different parts of law, although often used interchangeably in legal or medical practice. Even the definitions thereof overlap. One definition says medical law is the "*branch of law that concerns the rights and duties of the medical profession and the rights of the patient; main areas including the ethics and confidentiality law, the negligence and malpractice tort law*

[50] USLegal [online]. 2001-2010 [cit. 2010-08-01]. Health Law and Legal Definition. Available at: < http://definitions.uslegal.com/h/health/>.

and the criminal law related to medical practice". [51] Another one describes medical law, in its narrow sense, as only "*the rules and regulations associated with the doctor-patient relationship*", while in the broader sense, medical law is interchangeable with health law and means "*the law relating to health care*". [52] As for health law, Texas Board of Legal Specialization defines health law as "*federal, state and local law, rules, regulations and other jurisprudence affecting the health care industry, and their application to health care patients, providers, payers and vendors to the health care industry, including relations among providers, payers, vendors to the health care industry and its patients and delivery of health care services*". [53] More plainly said, health law is "*the area of law concerned with the laws governing interactions between physicians and patients as well as the laws regulating health care organization and provision*". [54] To make this definition disorder complete, let´s add one of health care law definitions. According to legal encyclopedia, health care law is "*the collection of rules governing the health care, including torts, contracts, antitrust and insurance*". [55]

For the purposes of this thesis we consider medical law as part of health law that concerns particularly the rules related to medical practitioners´ duties and the relations between doctors and patients. Health law and health care law are used interchangeably in the broadest sense of their definitions. Table 2.2.1 shows major issues we believe fall within the scope of health (care) law (medical law included).

[51] Lawbore : the law students´ guide [online]. 2010 [cit. 2010-08-01]. Medical Law. Available at: <http://lawbore.net/medical>.

[52] Health Law [online]. 10 June 2000 [cit. 2010-08-01]. Southern Medical Association. Available at: <http://www.sma.org.sg/cmep/healthlaw/HLA/HLA2.html>.

[53] Health law. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 23 August 2006, last modified on 30 July 2010 [cit. 2010-08-09]. Available at: <http://en.wikipedia.org/wiki/Health_law>.

[54] Health Law [online]. 10 June 2000 [cit. 2010-08-01]. Southern Medical Association. Available at: <http://www.sma.org.sg/cmep/healthlaw/HLA/HLA2.html>.

[55] West's Encyclopedia of American Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-01]. Available at: <http://www.answers.com/topic/health-care-law>.

Table 2.2.1: Major Health (Care) Law Areas

federal, state and local government regulations and policies related to health care	legal responsibilities of medical providers, practitioners and hospital (clinic) managers
confidentiality issues	informed consent issues
access to medical information	access to medical care and right for treatment
medical negligence and malpractice	doctor-patient relations
end of life issues	euthanasia
health care and health insurance contracts	antitrust and monopoly law of medical providers
fraud and abuse in health care and health insurance	abortion
death certification	health insurance and indemnity

On the other hand, health law does not include for example the regulation of pharmaceuticals, medical devices, drugs, foods, chemicals or social security. [56]

Out of all the areas within the health law, we focus on regulation of health insurance [57], medical malpractice, laws against fraud and abuse of health care, right for treatment and corresponding duty to provide medical care and antitrust and monopoly laws.

2. 2. 1 Medical Malpractice

Medical malpractice is "*a professional misconduct or lack of skill in providing medical treatment or services*". Although medical malpractice law is strongly linked to

[56] Cadwalader, Wickersham & Taft LLP. FindLaw : For legal professionals [online]. 1998 [cit. 2010-08-04]. An Overview of the Health Law Specialty. Available at: http://library.findlaw.com/1998/Jul/1/126786.html

[57] see chapters 3, 4 and 5

health care regulations and health care law, sometimes it is considered a specialty area of tort law instead of health law. [58] [59]

Medical malpractice is under the authority of the states, not the federal government. The primary sources of medical malpractice laws are the malpractice lawsuits decisions themselves. Since the precedents established in one state do not apply in other state, rules for malpractice may vary among the states. [60]

Medical malpractice occurs when a medical practitioner proceeds in a negligent conduct when treating a patient. The misconduct may arise out of action and/or inaction, i.e. failure to take a medically appropriate action. Examples are failure to diagnose a disease, misdiagnosis, failure to provide appropriate treatment for a medical condition or delays in treatments. [61] Victims of medical malpractice or negligence seek compensations through a "negligence action".

Several requirements must be met for a case to constitute a strong malpractice case. Usually, the case is acknowledged if a plaintiff (e.g. a patient, spouse of patient) proves the following: "(1) the defendant physician owes the patient a duty of care and was required to meet or exceed a certain standard of care to protect the patient from injury; (2) the defendant physician breached the duty or deviated from the applicable standard of care; (3) the patient was injured and the injury proximately resulted from the physician´s breach of the standard of care". These requirements come from the decision of the Court of Appeals of the state of Kansas - *Munoz v Clark*, 2009. The decision continues: "The elements of negligence are never presumed. Therefore, expert testimony is generally required to establish the appropriate standard of care and causation because such matters are outside the knowledge of the average person without specialized training. In certain medical malpractice claims, expert testimony is not required because the standard of care and causation are within the common knowledge

[58] Cadwalader, Wickersham & Taft LLP. FindLaw : For legal professionals [online]. 1998 [cit. 2010-08-04]. An Overview of the Health Law Specialty. Available at: http://library.findlaw.com/1998/Jul/1/126786.html

[59] West's Encyclopedia of American Law : Health Care Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-02]. Available at: <http://www.answers.com/topic/health-care-law>.

[60] BUDETTI, Peter P. Medical Malpractice Law in the United States [online]. [s.l.] : Kaiser Family Foundation, May 2005 [cit. 2010-08-02]. Available at: <http://www.kff.org/insurance/7328.cfm>.

[61] HG.org : Worldwide Legal Directories [online]. 1995-2010 [cit. 2010-08-02]. Medical Malpractice Law. Available at: <http://www.hg.org/medical-malpractice.html>.

of a layperson. But, the application of the common knowledge exception is extremely limited". [62]

The final step in a (successful) negligence lawsuit is establishing the amount of compensation to the patient. The monetary award is called "damages" and includes both economic (loss of wages, cost of medical care) and non-economic (pain, loss of a loved one) losses. The awarded damages are quite high since they are supposed to have a precautionary effect. However, states have adopted so called "caps" to limits the size of the damages. While some states limit only the non-economic damages and leave the economic damages´ size completely to judges´ discretion, others regulate the damages as a whole. A common cap of $ 250,000 on non-economic damages thus means that in a lawsuit the law prohibits a judge to award more than 250,000 as non-economic damages.

Regarding attorneys´ compensations, unlike in other lawsuits where each party pays for its lawyers whether they win or lose, in malpractice suits the attorneys usually receive the fee only upon winning the case. The fee is calculated as a percentage of awarded damages ("contingent fee arrangement"). The downside of the contingent fee arrangement is that the lawyers only take the cases which are presumed "winnable", leaving the patients with ordinary or not so strong claims without legal representation. The fee for malpractice ranges from 30 % to 50 % of the awarded damages. Some states regulate the limits for attorney fees as well, for example by explicitly stating the percentage of damages an attorney is entitled to in malpractice lawsuits. The percentage usually depends on the size of awarded damages. The common practice of such regulation is that the fee percentage progressively decreases as the awarded damages increase.

Physicians often purchase malpractice insurance to protect themselves against malpractice suits. The premiums of all malpractice insurances combined total billions of dollars each year and add significantly to the cost of the U.S. health care. As a consequence of the physicians´ fear of being sued, physicians actually started to practice "defense medicine", i.e. order unnecessary tests to prove they have done everything

[62] DUHAIME.org : Law + Legal Information = Justice [online]. 2009 [cit. 2010-08-02]. Medical Malpractice. Available at: <http://www.duhaime.org/LegalDictionary/M/MedicalMalpractice.aspx>.

possible in that particular case, sadly adding another unnecessary $ 85 - 151 billion a year to the total health care bill. [63] [64]

Medical malpractice lawsuits significantly negatively affect the relations between patients and physicians. Apart from accumulating tension between patients and their physicians, the rising number of malpractice suits results in higher prices of malpractice insurance, which further increases the cost of health care services. Malpractice litigations [65] can be very costly as well, even if dropped, withdrawn or dismissed without payment. Still, the average cost of defending such claim is approximately $ 22,000. Therefore physicians try to prevent potential malpractice liability in any way they can think of. For example, some physicians have recently started to refuse to see the patients with health conditions that are, according to the physicians´ opinions, risky for possible malpractice liability. [66]

The experts (e.g. the AMA) hence call for medical malpractice liability reform to stop these absurd practices, which only add to overall health care costs. Most states have already adopted legislation to prevent unnecessary malpractice lawsuits, mostly by imposing more duties on plaintiffs to ensure the relevance of each case since physicians are found not guilty in more than 90 % of the cases. [67] These new obligations of plaintiffs typically include obtaining an affidavit of an expert witness (e.g. another physician) certifying among others that the applicable standard of care was actually violated by the defendant physician, and a shorter statutes of limitations for filing a lawsuit. [68] Although the limits on the malpractice damages implemented by state laws have already proved to lower the malpractice insurance premiums by one third, additional actions need to be taken, especially on federal level. The AMA currently leads aggressive, multilayer campaign to lower liability costs and to urge Congress to

[63] West's Encyclopedia of American Law : Health Care Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-02]. Available at: <http://www.answers.com/topic/health-care-law>.

[64] American Medical Association. The Case for Medical Liability Reform [online]. [s.l.] : [s.n.], 2009 [cit. 2010-08-10]. Available: <http://www.ama-assn.org/ama1/pub/upload/mm/-1/case-for-mlr.pdf>.

[65] a litigation is a process of taking a case through court to be resolved

[66] one in 12 obstetricians with malpractice liability concerns claims to have stopped delivering babies due to fear of malpractice allegation

[67] average defense cost in a case where a physician is found not guilty is $ 110,000

[68] statutes of limitation vary among states, but usually there is a period ranging from 1 to 4 years from the occurrence of an injury within which the plaintiff may file a malpractice suit

pass legislation balancing the doctor-patient relations and enacting federal caps on non-economic damages. [69] [70]

Here are examples of (sometimes obviously negligent) conducts resulting in malpractice lawsuits: [71]

- death during routine cosmetic surgery
- delayed cesarean section during child birth causing brain damage
- a patient husband´s sperm was accidentally used to inseminate wrong woman
- healthy lung removal due to misdiagnosis of cancer
- a drunk doctor fell asleep during liposuction surgery
- a patient suffered severe burns during surgery when the antiseptic on the patient caught fire
- the wrong leg was removed during amputation procedure
- a patient awakens from anesthesia during surgery
- Michael Jackson, the famous singer, died from drug poisoning while under care of the personal physician (a combination of countless drugs was found in his system; the personal physician is being charged with involuntary manslaughter for delays in calling ambulance and for giving Michael Jackson too many powerful drugs at once). [72]

The following figures show the development of average and total medical malpractice claim payments (i.e. awarded damages on average) from 1991 to 2009, both inflation adjusted and unadjusted. Physicians´ malpractice records are found in the National Practitioners Data Bank of the federal government. Some states maintain similar databases on local levels.

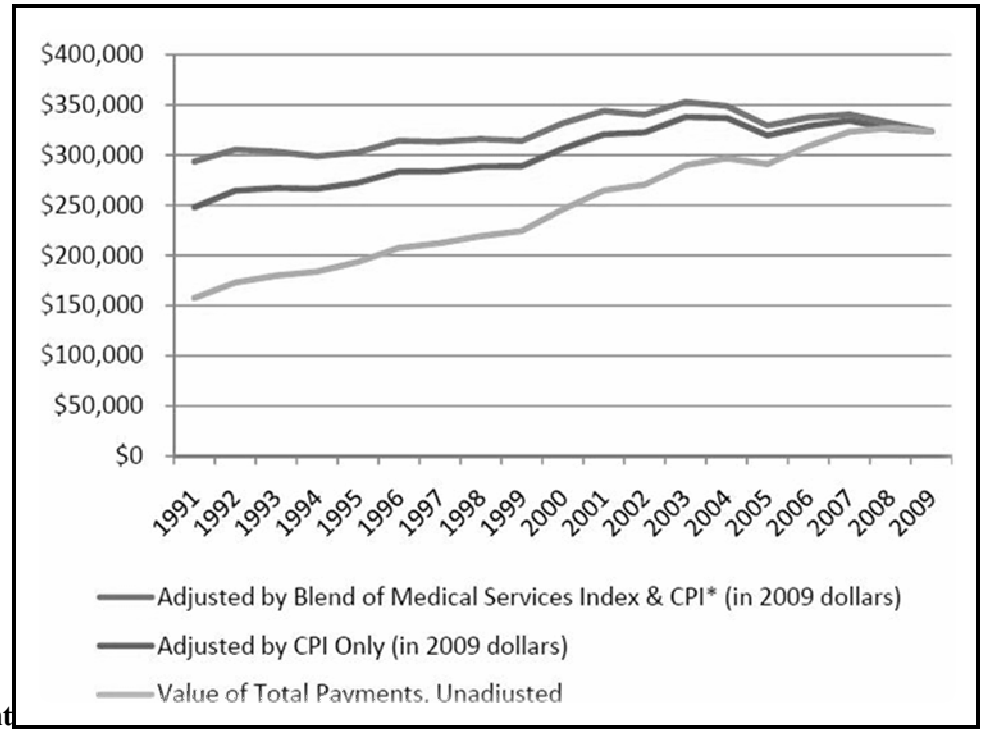
[69] American Medical Association. The Case for Medical Liability Reform [online]. [s.l.] : [s.n.], 2009 [cit. 2010-08-10]. Available: <http://www.ama-assn.org/ama1/pub/upload/mm/-1/case-for-mlr.pdf>.

[70] BUDETTI, Peter P. Medical Malpractice Law in the United States [online]. [s.l.] : Kaiser Family Foundation, May 2005 [cit. 2010-08-02]. Available at: <http://www.kff.org/insurance/7328.cfm>.

[71] PATIL, Sayali Bedekar. Buzzle.com : Intelligent Life on the Web [online]. 2010 [cit. 2010-08-02]. Medical Malpractice Cases. Available at: <http://www.buzzle.com/articles/medical-malpractice-cases.html>.

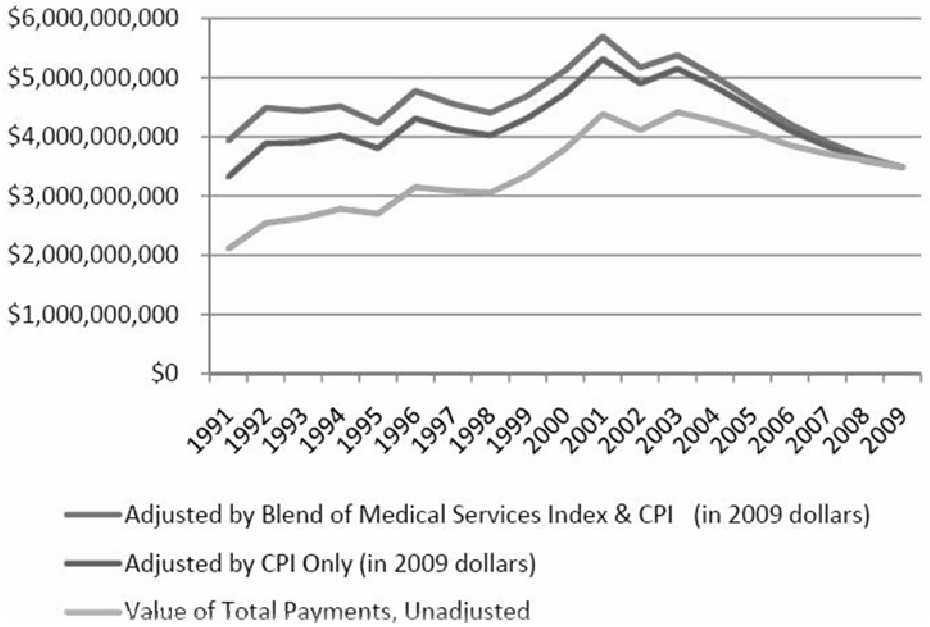
[72] DOBUZINSKIS, Alex. ABC CBN news.com [online].Reuters, 26 June 2010 [cit. 2010-08-02]. Michael Jackson's dad sues doctor over singer's death. Available at: <http://www.abs-cbnnews.com/entertainment/06/26/10/michael-jacksons-dad-sues-doctor-over-singers-death>.

Figure 2.2.1.1: Average Medical Malpractice Payment



Source: Public Citizen. Medical Malpractice Payments Fall Again in 2009 [online]. [s.l.] : [s.n.], 3 March 2010 [cit. 2010-08-03]. Available at: <http://www.citizen.org/documents/NPDBFinal.pdf>.

Figure 2.2.1.2: Total Value of Medical Malpractice Payments



Source: Public Citizen. Medical Malpractice Payments Fall Again in 2009 [online]. [s.l.] : [s.n.], 3 March 2010 [cit. 2010-08-03]. Available at: <http://www.citizen.org/documents/NPDBFinal.pdf>.

Due to states´ actions, medical malpractice payments have finally started to decline since the beginning of 2009. However, not everyone is pleased with the recent development. Public Citizen, a very active non-profit organization representing consumer interests, is convinced that malpractice payments and damages are too low to provide real compensation for suffered injuries and that the epidemic of medical errors is the main problem in medical malpractice. Various studies have estimated that approximately 44,000 to 200,000 people die annually due to avoidable medical errors. Since there were only 3,537 medical malpractice payments due to negligent deaths in 2009, that leaves, according to Public Citizen organization, between 83 % and 98 % of deaths without imposing any liability or payment. A total of only 10,772 malpractice payments were made on behalf of doctors in 2009. This proves that most victims of malpractice do not sue (for various reasons) and thus medical errors may pass by unchecked. Public Citizen also claims that all so called "malpractice liability reforms" are divorced from the real data and the only solution is to reduce or eliminate medical errors. "The need to redress has to be reduced, not the right to redress." Any other efforts only suppress the symptoms and do not cure the cause, thus resulting just in increase of health care costs.

The vast majority of medical malpractice payments compensated serious injuries or deaths occurred due to negligence, as showed in Table 2.2.1.3. [73] The question remains whether it is the result of states´ legislation eliminating frivolous claims, or whether the malpractice lawsuits really deal only with serious medical misconducts. However, we should not forget that large part of claims is withdrawn, dismissed or dropped before the actual litigation, partially because of its non-relevance, frivolousness or inability to prove the defendant´s guilt.

Table 2.2.1.3: Distribution of Medical Malpractice Payments by the Type of Injury in 2009

Injury Type	Frequency	Total Value of Payments ($)	Percentage
Death	3,537	1,116,251,850	32.0 %

[73] Public Citizen. Medical Malpractice Payments Fall Again in 2009 [online]. [s.l.] : [s.n.], 3 March 2010 [cit. 2010-08-09]. Available at: <http://www.citizen.org/documents/NPDBFinal.pdf>.

Significant Permanent Injury	1,659	646,629,800	18.5 %
Major Permanent Injury	1,190	631,127,850	18.1 %
Quadriplegic, Brain Damage, Lifelong Care	562	476,109,750	13.7 %
Minor Permanent Injury	1,258	252,779,300	7.3 %
Major Temporary Injury	1,158	227,192,300	6.5 %
Minor Temporary Injury	982	88,339,450	2.5 %
Cannot be determined	89	23,570,750	0.7 %
Emotional Injury Only	168	17,561,750	0.5 %
Insignificant Injury	169	8,581,300	0.3 %
Total	**10,772**	**3,488,144,100**	**100.0 %**

Federal government has already moved toward better patient safety. In 2000, the Institute of Medicine (IOM) published a report entitled "To Err is Human: Building a Safer Health System". The report estimated that approximately 98,000 people die in the U.S. each year due to medical error. Consequently, the IOM suggested that health care providers should voluntarily report errors and mistakes, these mistakes would then be evaluated and thus main weaknesses in the U.S. health care delivery would be identified. As a response, Congress passed the Patient Safety and Quality Improvement Act in 2005 (PSQIA), as an amendment to the Public Health Care Act. The PSQIA encourages voluntary reporting of errors and adverse events by medical providers themselves and creates so called "Patient Safety Organizations" (PSO) to collect and analyze these events in order to identify main issues in the current health care delivery. Medical providers submit reports or statements containing the description of adverse events (referred to as "patient safety work product" or "PSWP") to PSO. PSO analyzes

the report, removes data identifying providers or patients and submits the data into the "Network of Patient Safety Databases" (NSPD). The NSPD contains large volumes of data and thus is able to identify patterns of mistakes. Since the success of the PSQIA depends on providers voluntarily reporting medical errors, the Act contains confidentiality protection clause prohibiting the use of any reported information in civil and criminal procedures, medical malpractice litigation included. [74]

In the cases of severe malpractice (e.g. extended injuries, death), hospitals or even the association of hospitals are held liable, providing a patient with an additional source of money for compensation. But there are limits for passing the liabilities along hospitals. First, every state prohibits the practice of medicine without medical license. Since business entities cannot obtain such license, each physician is an independent contractor unless an explicit employment contract exists. Moreover, there are historical statutes prohibiting the employment of physicians, therefore in states where such law is still in effect, the claims cannot be brought against hospitals since the physicians are not their employees. Courts, however, generally look beyond the title given to the relationship and explore the nature of the hospital-physician relation on the grounds of a "respondeat superior" theory. If the relation in its core basically corresponds to the employment relationship under a different title or contract, the liabilities may be passed along the hospitals. If the relation is truly of an independent contractor a client, the liability may not be imputed. Another legal concept used in malpractice suits to impute the liability to hospitals is the "ostentible agency" theory. Unlike in respondeat superior, no employment relationship needs to be proved for the liability to pass along. It is sufficient if the principal (i.e. hospital) creates the appearance to third parties that the physician is an agent controlled by the principal. This concept focuses on reasonable expectations that a patient might have based on the actual conduct of the hospital organization. The actual legal relation of the physician and the hospital is completely irrelevant. [75]

Not only physicians or hospitals are subject to health care related lawsuits. Pharmaceutical companies or chemical producers are sometimes held liable for certain

[74] JUILLET, Jeanine. Health Reform Watch [online]. 25 April 2010 [cit. 2010-08-10]. Recent Developments in the Implementation of the Patient Safety and Quality Improvement Act of 2005. Available at: <http://www.healthreformwatch.com/2010/04/25/patient-safety-and-quality-improvement-act-of-2005/>.

[75] West's Encyclopedia of American Law : Health Care Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-02]. Available at: <http://www.answers.com/topic/health-care-law>.

health issue of patients if alleged. These cases, however, do not fall within the scope of malpractice.

In all health related cases (medical malpractice, disputes with pharmaceutical companies), the ruling depends largely on the quality of the expert witness´s testimony and evidence. One of the most famous cases is *Daubert v Merrell Dow Pharmaceuticals*, 1993. [76] This case changed the way the legal system looks at expert´s witnesses and their evidence. Petitioners, two minor children and their parents, alleged in this suit against Merrell Dow Pharmaceuticals that the children´s serious birth defect had been caused by the mother´s prenatal use of prescription drug Bendectin marketed by the former. The District federal court ruled in favor of the defendant because the evidence provided by the plaintiff failed to show the link between Bendectin and the birth defects of Jason Daubert and Eric Schueller, plaintiff´s children, while the defendant´s evidence was based on "generally accepted techniques" (unlike the plaintiff´s evidence) and proved the opposite. The plaintiff´s evidence was based on animal studies, pharmacological studies and reanalysis of published studies and these had still not gained the acceptance of scientific community according to the court. Even the Court of Appeal and the Supreme Court ruled in favor of the defendant. They felt the plaintiff generated evidence only for the purposes of litigation. The Courts applied so called "Federal Rules of Evidence" that allowed the trial judge to determine whether the evidence given by the expert witness is scientifically relevant to the case. After this case, expert witness testimony was made way more stringent as it could bring down the whole lawsuit. Now, all federal courts and most state courts use the Federal Rules of Evidence in similar litigations.

2. 2. 2 Fraud and Abuse

Fighting fraud and abuse in the health care industry is currently the second-highest priority of the U.S. Department of Justice right after violent crime. Health care lawyers therefore focus on prevention and correction of possible violations of the so called "fraud and abuse laws".

[76] Cornell University Law School : Legal Information Institute [online]. 2010 [cit. 2010-08-03]. Daubert v. Merrell Dow Pharmaceuticals. Available at: <http://www.law.cornell.edu/supct/html/92-102.ZS.html>

Fraud and abuse laws contain: [77]

- Federal Fraud and Abuse Statutes

Federal Civil Monetary Penalties (Section 1128A of the Social Security Act/42 USC 1320a-7aa)	"*Health care professionals and entities are prohibited from presenting or causing to be presented claims for services that the individual or entity "knows or should know" were not provided as claimed.*" This provision prohibits providing false or misleading information on health coverage claims, e.g. to state on claims that home health care requirements were met when they were not or to charge a service that has not been provided at all. Fines up to $ 15,000 a case apply.
Anti-Kickback[78] Law/Criminal Penalties for Acts Involving Federal Health Care Programs (Section 1128B of the Social Security Act/42 USC 1320a-7b)	"*Individuals and entities are prohibited from knowingly and willfully making false statements or representations in applying for benefits or payments under all federal and state health care programs. Individuals also are prohibited from fraudulently concealing or failing to disclose knowledge of an event relating to an initial or continued right to benefits or payments.*" The law also prohibits "*soliciting or receiving any remuneration (kickbacks, bribes, rebate) directly or indirectly, in cash or in exchange for referrals; or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a*

[77] American Medical Association [online]. c1995-2010 [cit. 2010-08-02]. Federal Fraud and Abuse Laws. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/health-care-fraud-abuse/federal-fraud-enforcement-physician-compliance/federal-fraud-abuse-laws.shtml>.

[78] kickback = bribe

	Federal health care program." Penalties include felony conviction (imprisonment for up to five years) and a fine up to $ 25,000. So called "safe harbors" define payment practices that are not prohibited. The government must prove that the conduct was knowing and willful. Federal Courts are of different opinions when it comes to actually proving the conduct. The U.S. Court of Appeals held in 1995 that the conduct is knowing and willful only if the defendant knows of this particular statute (*Hanlester Network v Shalala*, 9th Circuit of the U.S. Court of Appeals). In 1996 in *the United States v Juin*, the 8th Circuit ruled it is sufficient if the defendant knows that the conduct is wrongful. As a result, a middle ground prevails now (*United States v Starks*, 1998, 11th Circuit of the U.S. Court of Appeals) and usually it suffices if there is a proof of the intent to "disobey or disregard the law" in general.[79]
Stark I, II Limitations on Certain Physician Referrals (Section 1877 of the Social Security Act/42 USC 1395nn)	Stark I prevents physicians (and their family members) who have some business relationship with a clinical laboratory services facility from making referrals to it. Stark II extends the above prohibition on a business relationship with "designated health services" where Medicare payments are made and bans referring patients to these services. Designated services include apart from clinical laboratory services physical therapy services,

[79] MCCARTY THORNTON, D. Compliance Institute [online]. March 2005 [cit. 2010-08-03]. Fundamentals of the Anti Kickback Law. Available at: <http://www.compliance-institute.org/pastCIs/2005/Session%20W2/Legal%20Primer%20101%20-%20Thornton.pdf>.

	occupational therapy services, prosthetics and orthotics, home health services, hospital services etc. Such service cannot bill the services provided for the referred patients. Penalties are up to $ 15,000 per each service plus denial of payment for the provided service. Referrals through prepaid health plans are exempt from this regulation.
Federal Civil False Claims Act (31 USC 3829-3733)	Under this Act, anyone who "*knowingly makes, uses, causes to be made or used, a false record or statement to get a false or fraudulent claim paid and approved by the government*, is held liable and faces severe penalties.

- Health Care Program Administration Statutes

Exclusion from Federal Health Care Programs (Section 1128(a), (b) and (c) of the Social Security Act/42 USC 1320a-7a)	Individual or entities convicted for a health care program related crime, a criminal offense relating to patient abuse or negligence, a felony offense related to health care fraud, or a felony offense related to controlled substances must be excluded from Medicare and Medicaid for the period of at least 5 years. If there is a prior conviction, the exclusion is permanent.
Fraud and Abuse Control Program (Section 1128C of the Social Security Act/42 USC 1320a-7a)	The HHS was authorized to design, implement and coordinate the federal Fraud and Abuse Control Program. The program coordinates federal, state and local law enforcement programs to control fraud and abuse in health plans, conducts investigation, facilitates fraud and abuse law enforcement, issues special fraud alerts etc.

Health Care Fraud and Abuse Control Account (Section 1817 of the Social Security Act/42 USC 1395i (k))	This account, established by the HIPAA, funds activities of the HHS, FBI and Department of Justice (DOJ) related to the costs of administration and operation of the health care fraud and abuse control programs. In 2009, the U.S. government received $ 1.63 billion in judgments and settlements. Out of 1,014 criminal health care fraud cases, 586 defendants were convicted. Additional 886 civil health care fraud investigations were opened. The account spent $ 465 million on its activities in 2009.[80]
Medicare Integrity Program (Section 1893 of the Social Security Act/45 USC 1395ddd)	Under this program, the HHS contracts with private organizations to, among others, review the activities of health care professionals for which Medicare payment may be made and whether the payment should be made and to audit cost reports.
Beneficiary Incentive Programs (Section 203 of HIPAA/42 USC 1395b-5)	This program encourages individuals to report information on health care professionals and entities they suspect to engage in fraud or abuse of the Medicare program. Where a beneficiary reports information that serves as a basis for collection of at least $ 100.0, a portion of the amount collected from penalties is paid to that individual.
Safe Harbor; Advisory Opinions; Fraud Alerts (Section 1128D of the Social Security Act/42 USC 1320a-7d)	HHS annually proposes modifications to existing safe harbors or prepares new safe harbors. HHS in consultation with DOJ offers legally binding advisory opinions to health care providers on certain issues relating to fraud

[80] The Department of Health and Human Services and the Department of Justice. Health Care Fraud and Abuse Control Program : Annual Report for Fiscal Year 2009 [online]. [s.l.] : [s.n.], May 2010 [cit. 2010-08-04]. Available at: <http://www.justice.gov/dag/pubdoc/hcfacreport2009.pdf>.

	and abuse laws, e.g. what constitutes a prohibited remuneration under the anti-kickback law. HHS also informs public of suspicious or fraudulent practices.

- Crimes created by HIPAA but not specific to HIPAA

Health Care Fraud and Abuse Data Collection Program (Section 1128E of the Social Security Act/42 USC 1320a-7c)	This is a central health care fraud and abuse database for final adverse actions against health care professionals, providers and suppliers. It does not include claims where no liability findings have been made.
Health Care Fraud and Scheme (18 USC 1347)	It prohibits "knowing and willful actions or attempts to execute a scheme to defraud and heath care benefit program" or to falsely and fraudulently obtain money or property owned or controlled by health benefit program. Penalties include imprisonment for up to 20 years or up to life if death was caused.
Theft or Embezzlement in Connection with Health Care Benefit Program (18 USC 669)	It prohibits "knowingly and willfully embezzling, stealing, or otherwise without authority converting or intentionally misapplying money or property of a health care benefit program". Penalties also include imprisonment, this time up to 10 years.
Obstruction of Criminal Investigations of Health Care Offenses (18 USC 1518)	Anyone who willfully prevents, obstruct, misleads or delays the criminal investigation of federal health care offense may be imprisoned up to 5 years.
False Statements Relating to Health Care Matters (18 USC 1035)	Anyone who falsifies or conceals a material fact or makes a false fictitious or fraudulent statement in connection with the delivery or payment of health care benefit or service faces up to 5 years of imprisonment.

Almost every transaction involving health care providers may implicitly result in violation of fraud and abuse laws. For example innocent billing errors may result in massive penalties under the False Claims Act. Not only health care providers, but also insurers may violate the law if they e.g. improperly collect payments from public health insurance programs. Therefore all health care lawyers recommend adopting effective internal compliance programs to make sure no laws are breached. [81]

2. 2. 3 Right for Treatment, Duty to Provide Medical Treatment [82]

A physician has no duty to accept a patient, regardless of severity of the patient´s condition. The doctor-patient relationship is completely voluntary, based on a private contract. Once the contract exists, the physician is a fiduciary in respect of providing medical treatment, i.e. the physician has legal obligation to provide medical treatment primarily for the benefit of the patient. If the physician then refuses care or treatment, a liability is imposed based on the "theory of abandonment". Generally, abandonment is an intentional act to refuse treatment or to misconduct while malpractice is negligent lack of care or treatment or misconduct. The physician under a treatment contract must provide all necessary treatments to a patient unless the relationship is ended by the patient or by the physician. Should the physician terminate the relationship, he/she must do so with a sufficient notice to enable the patient whose care is being discontinued to find another medical care provider. The fiduciary nature of medical care relationship may not be changed by the patient´s inability to pay. Even when funds are not reimbursed as expected, health care providers must notify a patient of the discontinuing of medical care with the proper notice and even help find him alternative care. Reimbursement issues are very common in the U.S. health care. Regulations often limit or cut off the funding for a patient´s care. For example, under the diagnosis-related group system of Medicare, Part A[83], a hospital is paid a preset amount for the treatment of a particular diagnosis regardless of the actual hospital´s costs. Hospital then needs to find own funds to fill the resources gap. Privately insured patients often lose health

[81] Cadwalader, Wickersham & Taft LLP. FindLaw : For legal professionals [online]. 1998 [cit. 2010-08-04]. An Overview of the Health Law Specialty. Available at: http://library.findlaw.com/1998/Jul/1/126786.html

[82] West's Encyclopedia of American Law : Health Care Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-04]. Available at: <http://www.answers.com/topic/health-care-law>.

[83] Medicare is a public health insurance program mostly for the elderly. See chapter 5 for more information.

coverage as soon as they fail to pay premiums. If that happens, and unless they qualify for public health programs, they are required to pay all the health care costs out-of-pocket.

Hospitals, unlike physicians, must acknowledge the common practice that the society expects an emergency case patient in an "unmistakable emergency" seeking medical care to be provided with reasonable care in a hospital. Searching for alternative care in a time-sensitive emergency could result in permanent injury or even death and thus hospitals are subject to more duties when admitting patient for a treatment. In the 1980s, many private hospitals due to rising health care cost started "patient dumping" (refusing to admit indigent patients and instead transferring them to emergency rooms at municipal or county hospitals). Various laws, even federal, later prohibited this practice, e.g. the Consolidated Omnibus Budget Reconciliation Act of 1985, a section titled Emergency Medical Treatment and Active Labor Act (EMTALA). Under the EMTALA, all hospitals that receive federal assistance, maintain charitable non-profit tax status or participate in Medicare are prohibited from denying emergency treatment based solely on a patient´s inability to pay. This means basically all U.S. hospitals with few exceptions, such as the Indian Health Service hospitals or Veterans Affairs medical facilities. Penalties include large fines for hospitals who fail to enforce this regulation. The unlawful denial of treatment is also the reason for private lawsuits against hospitals. Hospital may never deny a patient whose life is in serious jeopardy or pregnant women in active labor. However, if a patient is stabilized to the point that transfer to another hospital will not result in material deterioration of the patient´s health, the EMTALA law does not have to be applied. Other federal statutes (e.g. 42 USCA 2000d [84]) require hospitals that receive federal assistance (almost all hospitals) to treat all the patients with the ability to pay, regardless the race, color, nationality, legal status or other discriminatory bases. The Rehabilitation Act of 1973, section 504, prohibits federally funded programs and activities (hospitals receiving federal assistance included) to exclude any handicapped individual solely for the person´s handicap. [85] AIDS/HIV symptoms are considered handicap under this statute and therefore hospitals receiving federal funds may not deny treatment to patients who suffer this disease. At the state

[84] USCA (= United States Code Annotated) combines the official text of the USC laws with comprehensive coverage of case law

[85] a physical or mental impairment that substantially limits one or more of a person´s major life activities

level, similar legislation exists and generally applies to all state-licensed health care facilities and physicians, i.e. to all health care providers in the state.

2. 2. 4 Antitrust and Monopoly in Health Care [86] [87]

The same antitrust and monopoly laws that govern business entities apply to medical care providers and health care organizations. The most important statutes are the Sherman Anti-Trust Act of 1890 (SAA) [88], the Clayton Anti-Trust Act of 1914 (CAA) and the Hart-Scott-Rodino Antitrust Improvement Act of 1976 (HSR). The DOJ and the Federal Trade Commission (FTC) supervise and enforce the federal antitrust and monopoly laws. State laws are patterned after SAA and CAA. State agencies oversee the compliance with state laws. As a result, state and federal powers often overlap and both state and federal agencies sometimes end up investigating the same case of violation of antitrust and monopoly laws.

The SAA prohibits conspiracies in restraint of trade that affect interstate commerce or trade with foreign nations in Section 1. Section 2 prohibits monopolization and attempts to monopolize in any part of trade or commerce among several states or with foreign nations.

In health law, violation of the SAA is often alleged in lawsuits where physicians sue hospitals and the medical staff for denial of admittance to (or expulsion from) the hospital staff. Physicians generally do not work only for a particular hospital, but instead are members of several hospitals. The medical staff of the certain hospital admits the particular physician according to its by-laws. The physicians are then periodically re-evaluated and failure to perform according to medical staff´s wishes may result in expulsion. If a lawsuit occurs, physicians claim that they are being illegally restrained from trade (i.e. practicing medicine). If they allege violation of the SAA, three conditions must be met. First, a conspiracy must be present. Normally, a single business (hospital) cannot conspire with itself to restraint trade. But physicians as

[86] West's Encyclopedia of American Law : Health Care Law [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-04]. Available at: <http://www.answers.com/topic/health-care-law>.

[87] FELDMAN, Roger. Antitrust Policy in Health Care : Searching for a strategy that works [online]. [s.l.] : University of Minnesota, 2009 [cit. 2010-08-18].
Available at: <http://www.iom.edu/~/media/Files/Activity%20Files/Quality/VSRT/Cost%202/9-Antitrust%20Policy%20in%20Health%20Care.pdf>.

[88] the SAA is the first measure passed by the U.S. Congress to prohibit trusts

medical staff are independent contractors and individual business entities, therefore when they exercise their voting right to admit or expel another physician, they fall right within the SAA´s definition of conspiracy. Secondly, a restraint of trade must occur. Courts interpret and decide whether an illegal restraint of trade occurred in the particular case. Thus, when medical staff denies admittance to someone with a history of unethical behavior, courts rule that the denial was independently justified. On the other hand, if there is only one hospital in town and its medical staff denies the admittance to a perfectly qualified physician, the SAA violation is, provided all other elements are present, affirmed and penalties follow. Third, the action alleged must substantially affect interstate commerce. This is because the federal courts have jurisdiction in commercial disputes only if interstate commerce is affected according to the U.S. Constitution. Courts´ decisions vary in this element. Some say the practice of a single physician has only minimal effect on interstate commerce, others focus on the activities of entire hospital and find that the jurisdiction exists (e.g. there is some federal funding).

The CAA prohibits mergers if they substantially lessen competition or tend to create a monopoly. A merger must not result in several large firms totally controlling the relevant market to be valid. The CAA may prohibit a national hospital management company from purchasing several hospitals in one town and also joint ventures between hospitals and physicians or in between physicians. However, any case of merger may present evidence that shows the relevant markets do not overlap and thus do not lessen the competition, and uphold the merger decision. As always, exceptions exist for applicability of the Act. For example, a hospital that would, without a merger, go bankrupt immediately, may exercise the merger.

The HSR amended SAA and CAA and established the federal premerger notification program. Both parties of certain mergers (the size of sales is the trigger for notification) must notify the DOJ and FTC in advance. Merger transactions cannot be closed until either DOJ or FDC evaluates the likely effect of the merger on competition.[89] Mergers of hospitals are most likely to be banned by the FTC. On the other hand, FTC or DOJ do not evaluate mergers of physician practices very often because the notification thresholds are too high for these kinds of mergers.

[89] Federal Trade Commission [online]. 13 August 2010 [cit. 2010-08-18]. Hart-Scott-Rodino Premerger Notification Program. Available at: <http://www.ftc.gov/bc/hsr/index.shtm>.

To get the idea about the scope of business law transactions involving health care, we provide several examples. When a company owns a health care provider and is sold, the areas that must be dealt with before closing the transaction include tax, corporate, commercial, real estate, intellectual property and licensing[90] issues, plus additional health care issues such as regulatory approval of the license transfer, Medicare, Medicaid or other third party payor liabilities, transfers or terminations of affiliations with other health care providers, residual malpractice, labor matters, tax liabilities if tax-exempt status will be lost etc. A merger of non-profit hospitals within one state would include regulatory approvals by the state health department, review by the Attorney General´s Charities Bureau, filings with the DOJ/FTC, filings with the Internal Revenue Service, negotiations with Medicare and Medicaid and other third party insurers over new reimbursement rates and both state and federal government approval if there are debts guaranteed by state or federal agencies. If a hospital has affiliations with some medical school or other academic organizations, the affiliated relations need to be renegotiated, approvals of a corporate parent company of medical school or academic organization are necessary as well and liability insurance needs to be taken care of. [91]

[90] production of pharmaceuticals and prescription drugs falls partially under IP law

[91] Cadwalader, Wickersham & Taft LLP. FindLaw : For legal professionals [online]. 1998 [cit. 2010-08-04]. An Overview of the Health Law Specialty. Available at: http://library.findlaw.com/1998/Jul/1/126786.html

3. HEALTH INSURANCE PLANS

Insurance, in general, is a legal promise to pay benefits if and when a certain event occurs. The insurer collects premiums from the insured, only a few of whom recover the whole sum of premiums. Thus, an insurer disposes a large sum of money and is able to cover the losses of those few insured who claim the benefits. The insurer also bears the risk of paying out large sums of money for the benefit of few insured. [92]

Health insurance is insurance that pays for all or part of person´s health care expenses. [93] In the U.S., private and public health insurance exists. While private health insurance has the closest resemblance to a regular commercial insurance contract (health insurance company pays for health care services in exchange for payment of premiums), public health insurance plans operate slightly differently. [94]

Health insurance plan refers to a certain more or less individualized health insurance policy (public or private), which specifies the covered health insurance benefits and the terms of the coverage thereof. In the U.S., a majority of population is expected to acquire health insurance by themselves, through a range of private health insurance plans. Federal and state governments help with health care expenses of only certain groups of people who, for various qualifying reasons, are not able to access private health coverage market and purchase health insurance.

Having some kind of health insurance is valuable for many reasons. Firstly, health insurance protects against uncertain and high health care expenses. Unpaid medical bills can add up and people lose property or even homes. Secondly, people with health insurance seek appropriate medical care in less severe stages of health condition than the uninsured and thus are more likely to receive effective treatment and be completely cured. The uninsured population actually forms majority of the emergency

[92] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

[93] Gale Encyclopedia of Cancer : Health Insurance [online]. [s.l.] : Thomson Gale, Inc., 2003 [cit. 2010-08-11]. Available at: < http://www.answers.com/topic/health-insurance>.

[94] a “beneficiary” is a person entitled to health insurance benefits (health insurance coverage); sometimes referred to also as a “client”, a “recipient”, an “insured”, an “enrollee”, a “policy holder” etc.

care patients in the U.S. People without health insurance mostly depend on the services of overcrowded county and charity hospitals where it takes hours or days to be seen. Thirdly, health insurance proof is often required when enrolling to college, getting a mortgage, purchasing life insurance etc. [95]

3. 1 Types of Health Insurance Plans

There are four basic types of health plans on the U.S. health insurance market, which further classify as either: (1) fee-for-service (or indemnity) care or (2) managed care. Each type has its advantages and disadvantages; however they do have one thing in common in the case of private health insurance. All require policy holders to pay periodical premiums to receive health coverage. The major differences concern the choice of a medical provider, amount of out-of-pocket costs and the method of payment of bills. Usually, indemnity plans offer free choice of a health care provider and reimburse the service after the bill has been issued. Managed care plans, on the other hand, limit the choice of a medical provider. They have agreements with certain physicians or hospitals, from which the clients must choose. The limitation in freedom to choose a medical provider is balanced by lower costs of managed care plans, because the insurers receive discount prices from the contractual medical providers in exchange for a certain volume of patients.

The difference between the types of health plans have been blurring recently. Now, mixed health insurance plans combining elements of various types have been establishing themselves on the market. [96]

3. 1. 1 Fee-for-Service Plans

Fee-for-service or indemnity health plans are the oldest and most traditional. A patient receives health care service and the insurance company pays the bill upon receiving a claim for a particular service. For example, if you get an x-ray and then consult the result with a physician, the hospital will issue the bill for x-ray and the bill for physician´s consult. The bill is sent to an insurer and the hospital is reimbursed the

[95] Mama´s Health.com [online]. 2000-2010 [cit. 2010-08-01]. The top 8 reasons why you need health insurance. Available at: <http://www.mamashealth.com/topten/hinsurance.asp>.

[96] Health Insurance Guide [online]. 2009 [cit. 2010-08-05]. The Types of Health Insurance . Available at: <http://www.healthinsuranceadvice.org/types.html>.

costs for the consult and for the x-ray. There are no limitations concerning the choice of a medical provider. However, before the insurance company starts reimbursing the costs, an annual deductible (usually few hundred dollars) must be reached. Once the deductible is exceeded, the insurance company pays the "usual and customary" charge for the services. Generally, an insurance company pays 80 % of the usual and customary charges and the client pays the rest (20 %). This is called the "co-insurance". Should the medical provider charge more than what is usual and customary, the insurance company still reimburses only 80 % of the usual and customary costs and the client needs to pay the 20 % co-insurance plus the difference between the actual costs and usual and customary costs. A fee-for-service health plan is sometimes referred to as a "major-medical" health plan. [97]

3. 1. 2 Managed Care

Managed care plans are health insurance plans that attempt to control the cost and quality of care for their members by coordinating medical and other health-related services. [98] Managed care health plans exist in three forms: Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) and Point-of-Service Plan (POS). Managed care system was established with the intent to reduce costs of health benefits and improve the quality of care. Sometimes the term managed care refers to a managed care organization, which is a business entity associated with the provision or operation of managed care plans.

The system of managed care was established by the Health Maintenance Organization Act of 1973 (HMO Act), a federal act providing a series of grants and loans to initiate creation of the HMOs, and requiring employers of more than 25 employees to offer a HMO plan alongside the usual indemnity health coverage. [99] [100]

[97] Health Insurance Guide [online]. 2009 [cit. 2010-08-05]. The Types of Health Insurance . Available at: <http://www.healthinsuranceadvice.org/types.html>.

[98] West's Encyclopedia of American Law : Managed Care [online]. [s.l.] : Thomson Gale, Inc., 1998 [cit. 2010-08-05]. Available at: < http://www.answers.com/topic/managed-care >.

[99] the obligation of an employer to offer at least one indemnity health insurance plan and one HMO health insurance plan is called the "dual-choice"; the "dual-choice" provision of HMO Act expired in 1995

[100] Health Maintenance Organization Act of 1973. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 8 August 2005, last modified on 23 March 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Health_Maintenance_Organization_Act_of_1973>.

States have intervened a lot in the managed care system, particularly during the late 1990s and early 2000s. Prepaid group practices, later known as the HMOs, were for a long time subject to vigorous opposition by the organized medicine associations, such as the AMA. Managed care also was not in compliance with the state´s requirement that all health plans enable free choice of physicians. States´ laws were preempted by the federal HMO Act in 1973.

The main strategy of managed care is to form a network of medical providers for its members only. This strategy allows the organizations to negotiate discounts with medical providers in exchange for steady flow of patients to associated practices or physicians. The nature of restrictiveness of networks is the primary factor for distinguishing among various managed care types. When managed care first appeared, "free choice of provider" laws were joined with "any willing provider" laws (AWPs). AWPs ensured that any provider willing to accept the terms offered by a managed care organization could join the network. Only five states apply AWPs now.

Managed care organizations work to reduce the costs under all circumstances and sometimes their terms are not particularly "patient-friendly". For example, states had to universally ban so called "gag clauses" in managed care contracts with providers that, among others, prohibited medical providers from discussing treatment options that were not covered by the health plan. Further, reports of managed care plans´ restrictions on coverage for hospital stay after childbirths led to states, and later even federal government, having to enact "drive through delivery" guaranteeing at least 48 hours of paid hospital stay after normal child delivery. By the late 1990s, states reached high coordination levels in their legislation. For example, almost all states adopted external review statutes, giving external review authority the power to review terms in managed care health plans. Some adopted laws limiting the strict policies of "no direct approach" to specialists. Laws protecting the interests of providers in disputes with managed care organization exist as well. Finally, states have adopted laws subjecting the managed care plans to liability for negligent denial of health coverage that cause injuries to their members. Congress seriously considered universal federal managed care legislation, but the events of 11 September 2001 intervened. [101]

[101] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

3. 1. 3 Health Maintenance Organization (HMO)

HMO is a type of a managed health insurance plan, in which the members pay a monthly or annual premium for health care provided through physicians and hospitals, with which the HMO has a contract. Unlike fee-for-service plans, HMO operates on a prepaid basis. Each patient has a primary care physician (PCP), usually general practitioner, pediatrician or family doctor, who coordinates the patient´s medical care, with the emphasis on preventive and primary care. In case a patient needs a special treatment, the PCP serves as a "gatekeeper" to direct access to a specialty care. A PCP´s referral to a specialist is required; otherwise the HMO will not pay for the health services. Benefits are provided through a network of providers only. Health care with others, not HMO related providers, is not covered (unless in emergency situations). [102]

HMOs focus on preventive health care to prevent the members from developing an avoidable condition. Therefore the preventive care is almost co-payment free. HMOs do not use deductibles; nevertheless they require co-payments for each doctor´s visit and hospital service. HMOs do not cover unnecessary medical care, thus elective plastic surgeries, cosmetic surgeries or experimental treatments will not be reimbursed.

Patients with some health conditions (e.g. asthma) are subject to "case management", where a group of similarly ill members receive a case manager that supervises their treatment to make sure the medical care of various providers does not overlap and financial resources are not wasted.

There are several ways how the HMO associates with medical providers. Under "staff model", the HMO directly employs physicians. Such physicians are then employees of the HMO only and may not see other patients. "Group-modeled" HMOs contract with a private practice of physicians with different specialties. Depending on the form of group model, physicians may or may not see other than HMO patients. In an "independent practice association model", a physician contracts with the association of independent physicians (IPA) founded to provide medical personnel to managed care organizations and the IPA contracts with the HMO. The last is a "network model", which is the combination of all the approaches above. The HMO contracts with a group

[102] so called "Open HMOs" do not require the PCP´s referral to reimburse a specialist payment

of physicians, individuals and IPAs all at once, thus creating a network of medical providers.

The HMOs are often criticized for strict limits for using services of other medical providers (which are either not reimbursed at all or come with a penalty co-payment) and for their guidelines, determining what health care services will be reimbursed. HMOs are sometimes sued for malpractice on the grounds that their guidelines prevent reimbursement for a necessary treatment. Both federal and state laws apply. [103] [104] [105]

3. 1. 4 Preferred Provider Organization (PPO)

The PPO is a relatively new type of managed care health plan. The PPO is an organization of physicians, hospitals and other medical professionals, which covenanted with an insurer (or a third party administrator) to provide health care for the insurer´s (or third party´s) members at reduced rates. Mostly, an insurance company organizes the PPO. [106] Unlike in HMOs, there is no obligation to select a PCP, only the option to. Usually, only patients who do not want to manage their health care themselves take advantage of the PCP´s services. The entry to other providers, even specialists, within the network is unlimited and no referral in required. Patients have the option to either visit only medical providers that are part of PPO network and receive medical services with discount, or to go "out-of-network" and pay more money for the health care services. If a patient decides to use the network medical providers, only a co-payment must be paid directly by the patient, all other costs are taken care of by the PPO. Generally most PPOs apply some annual deductibles before they start reimbursing the health care services; and thus patients are required to pay for the services themselves up to the amount of a deductible. When a deductible limit is reached, the PPO pays for all

[103] BAILEY, Eileen. Suite101.com [online]. 7 January 2008 [cit. 2010-08-05]. Types of Health Insurance. Available at: <http://health-insurance.suite101.com/article.cfm/types_of_health_insurance>.

[104] The Columbia Encyclopedia. Encyclopedia.com [online]. Sixth edition. 2008 [cit. 2010-08-05]. Health maintenance organization. Available at: <http://www.encyclopedia.com/topic/health_maintenance_organization.aspx>.

[105] Health Maintenance Organization. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 24 June 2002, last modified on 2 August 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Health_Maintenance_Organization>.

[106] Preferred provider organization. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 18 November 2004, last modified on 16 July 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Preferred_provider_organization>.

the costs, sometimes even without any co-payments for doctor´s visits. If a patient does not want to use the network health care services for any reason, he may visit any medical care provider he/she wishes, but on the condition that he/she pays for the medical services directly and then files a claim with the PPO to get partially reimbursed. The medical services outside of the PPO network are more expensive and the PPO does not reimburse all the money spent on such services. [107] Typically, the PPO covers about 80 % of the health care costs if within the network and less than 80 % if out-of-network. This arrangement is supposed to discourage patients from going out-of-network, because the cost of medical care service of a medical provider not associated with the PPO is much higher for both the PPO and the patient.

The PPO is more expensive version of managed care in comparison with the HMO. Usually, even if patients paid the same annual premium for both HMO and PPO, the other fees associated with the PPO would increase the total cost of insurance significantly. However, PPOs allow almost unlimited choice of medical providers. The usual costs of the PPO include, apart from yearly premium, a co-insurance and/or co-payment. Co-insurance is a certain percentage of actual cost of medical service, which a patient must pay alongside the premiums for certain medical services. Co-payment is a fixed amount for the use of a medical service, such as a $ 20.0 per each physician visit. Co-payments are generally used in preventive services while co-insurances in specialist treatments. With non-network medical care (and sometimes even with the network care), a deductible must be satisfied before the PPO starts contributing to pay for the services. After a deductible is met, only the co-insurance and/or co-payment apply. Higher co-insurance is set for out-of-network medical care. [108]

Advantages of the PPO include flexibility in the choice of a provider, even out-of-network; large network of medical providers; low costs when using the network medical services due to out-of-pockets annual limits; possibility to purchase discounted prescription drug supplementary coverage; and no obligation to see a primary care physician. Main disadvantages are the higher cost of the PPO when going out-of-network; obligation to administer all paperwork when receiving care from out-of-

[107] BIHARI, Michael. About.com : Health Insurance [online]. 15 April 2010 [cit. 2010-08-05]. HMOs vs. PPOs – What Are the Differences Between HMOs and PPOs?. Available at: <http://healthinsurance.about.com/od/understandingmanagedcare/a/HMOs_vs_PPOs.htm>.

[108] Health Insurance In-Depth [online]. 2002-2010 [cit. 2010-08-05]. PPO. Available at: <http://www.healthinsuranceindepth.com/policy-types-ppo.html>.

network (fill out forms and claims, send bills); larger co-payments in comparison with other managed care plans; and existence of a deductible. [109] [110]

3. 1. 5 Point-of-Service Organization (POS)

The POS is another type of managed care health program, combining elements of HMOs and PPOs. The POS is based on the crucial managed care foundation: reducing medical care costs in exchange for limited choice of medical providers. The POS requires its enrollees to choose a PCP to monitor and manage their health care. The PCP is from the POS network and is referred to as a "point-of-service" since the PCP´s referral is required to enter the services of specialized medical care, similarly as in HMOs. However, unlike in HMOs, the PCP may make referrals to health care providers outside the network. Naturally, the out-of-network services are provided for higher cost and only limited compensation is then paid by the POS, as in the PPOs, but at least the possibility exists. The POS is slightly less expensive than PPO, because the insurance company manages the health care to some point and limits the specialized treatments through existence of referrals. The actual costs consist of monthly premiums and co-payments for health care services within the network. For non-network care, there is a deductible on top of other costs. Up to the amount of set deductible, the insurance company does not compensate any health care costs at all. Once a deductible limit is met, generally co-insurance is used as a form of participation on all non-network health care services.

Advantages of the POS are: maximum freedom within the managed care concepts; unlimited choice of medical providers; low co-payments and no deductibles for network medical care; and limitation of annual out-of-pocket costs. Disadvantages include: high co-payments and prices in general for non-network care; deductible for non-network care; obligation to obtain referrals from the PCP. [111]

[109] MedHealthInsurance [online]. 2005-2010 [cit. 2010-08-05]. Preferred Provider Organization Plans (PPO Plans). Available at: <http://www.medhealthinsurance.com/ppoplan.htm>.

[110] Health Insurance Sort [online]. 2003-2010 [cit. 2010-08-05]. PPO Health Insurance. Available at: <http://www.healthinsurancesort.com/ppo.htm>.

[111] Health Insurance In-Depth [online]. 2002-2010 [cit. 2010-08-05]. POS Plans Offer Savings and Flexibility. Available at: <http://www.healthinsuranceindepth.com/policy-types-pos.html>.

3. 2 Consumer Driven Health Care (CDHC)

"Consumer driven health care is a type of health care financing designed to reduce health care spending by providing financial incentives for consumers to choose the best health care value." [112] In narrower sense, it refers to health insurance plans that allow members to use specified payment products to pay routine health care directly, while a high deductible or catastrophic health insurance plan[113] protects them from ruinous medical expenses for specialized health care.

In the U.S., health insurance market must offer various types of health insurance for the people to choose from. Whereas some people prefer costly comprehensive health coverage for all medical care they can think of, others may be interested in cheaper forms of health insurance reimbursing only for the most expensive procedures and services. High deductible health plans (HDHPs) are popular cheaper versions of health insurance with small monthly premiums. However, a patient needs to take into account that all routine health services will be paid out-of-pocket without any compensation from an insurance company. High deductibles of HDHPs are often paid for using the CDHC savings accounts.

The CDHC establishes pre-funded special savings accounts, from which the patients pay their out-of-pocket expenses for medical care (for example linked to HDHPs), usually with a special credit or debit card issued with the savings account. If the balance on the account runs out, patients then pay claims like under any other health insurance plan with deductibles. The CDHC shifts the burden of costs on consumers, and relies on the patients to find the best values for their money. The CDHC was created to give the patients greater control and responsibility over their health care expenses and to make them learn more about the actual costs of health care. Since the Medicare Modernization Act of 2003 (MMA), CDHC plans receive tax subsidies.

Special consumer driven payment models include: Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), Flexible Spending Accounts (FSA) and Medical Savings Accounts (MSA).

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[112] MONTGOMERY, Kelly. About.com : Health Insurance [online]. 31 December 2009 [cit. 2010-08-05]. Consumer-Directed Health Care. Available at: <http://healthinsurance.about.com/od/glossary/g/cdh.htm>.

[113] catastrophic health plan is a type of health insurance characterized by cheap premiums and high patients´ deductibles, that covers only very serious (i.e. catastrophic) medical conditions and anything less serious is excluded from the coverage

Under HSA model, special saving accounts accrue interests, which are free from federal income taxes. Banks are empowered to open tax free HSAs provided the consumer proves having purchased a HDHP. Consumers then deposit money approximately in the amount of annual deductible according to their HDHPs and withdraw the money when paying for the medical services. Any deposited amount of money exceeding the annual deductible is still tax free as long as used for medical services. [114]

Another form is the HRA, which represents an employer-funded account that reimburses employees for incurred medical expenses not covered by the employer-sponsored health insurance plans. Employer finances the account, and thus its contributions are tax deductible. Employees receive reimbursements tax free as well. Because the employer finances the account from its own funds, the decision whether to start or cancel the account is entirely on the employer´s side. [115]

The FSA is the third form of spending accounts. It is employer-established benefit plan reimbursing the employees for specified medical expenses. The FSAs fit among so called cafeteria plans[116]. Unlike in HRAs, employees contribute funds to the personal flexible spending account on the grounds of a salary reduction agreement. All contribution and withdrawals are both income tax and social security tax free. Some employers contribute as well as part of employment benefits. Employees forfeit any unspent funds in the account at the end of coverage period, therefore they must pay attention to their medical bills to have some kind of idea how much money should be deposited in the account. [117] [118]

[114] Consumer-driven health care. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 5 October 2006, last modified on 28 July 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Consumer-driven_health_care>.

[115] Investopedia [online]. 2010 [cit. 2010-08-05]. Health Reimbursement Account - HRA. Available at: <http://www.investopedia.com/terms/h/hra.asp>.

[116] an employee benefit plan that allows employees to choose from a variety of non-taxable benefits (health insurance, retirement benefits) to formulate a plan that best suits their needs; established in 1978 by the Revenue Act and currently regulated by section 125 of the IRC

[117] SALEEM, Haneefa T. U.S. Department of Labor : Bureau of Labor Statistics [online]. 2003 [cit. 2010-08-05]. Health Spending Accounts. Available at: <http://www.bls.gov/opub/cwc/cm20031022ar01p1.htm>.

[118] Encyclopedia of Small Business : Flexible Benefit Plan [online]. [s.l.] : Thomson Gale, Inc., 2002 [cit. 2010-08-05]. Available at: < http://www.answers.com/topic/cafeteria-plan>.

MSAs were associated with self-employed individuals and small businesses prior to the existence of HSAs. They have existed since 1997, when the HIPAA authorized their establishment. However, since the adoption of MMA in 2003, they have been superseded by HSAs and became rather obsolete. [119] Funds were controlled by the account holder. Either employee or employer made contributions, never both. To qualify, individual had to be either self-employed or an employee of the business with less than 50 employees, and own a HDHP. Savings could be transferred from one year to another. Funds were used to pay for long-term care insurance premiums, health insurance premiums during the period of unemployment, and for premiums for continuation of health insurance coverage after termination of formerly available health coverage for specified reasons under federal law. [120] Limits for maximum deposits applied. [121]

As always, there are pros and cons to this policy. Proponents argue that the Americans under these health plans will pay less in the long run for health care because of the lower monthly premiums and due to the fact that the competition on the health insurance market is further increased by the patients regulating their own expenses. In addition, consumers are becoming more aware of the actual costs of health care services. Critics, on the other hand, deny any value added to these plans since no patients can actually save on health care with deductibles set as high as $ 3,000 - 4,000. Furthermore, they claim that consumers will probably forgo necessary health care in order to save money. [122]

According to several studies, CDHC plans are expanding rapidly. In January 2010, about 10 million people were using some form of CDHC. CDHC plans are welcomed with enthusiasm by so called “decentralizers” of health care. Decentralizers believe, unlike “centralizers”, that individuals should be given an opportunity to make

[119] Medical savings account (United States). In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 25 January 2009, last modified on 25 April 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Medical_savings_account (United_States)>.

[120] for example the “termination of employment continuation” under the Consolidated Omnibus Budget Reconciliation Act

[121] SALEEM, Haneefa T. U.S. Department of Labor : Bureau of Labor Statistics [online]. 2003 [cit. 2010-08-05]. Health Spending Accounts. Available at: <http://www.bls.gov/opub/cwc/cm20031022ar01p1.htm>.

[122] MONTGOMERY, Kelly. About.com : Health Insurance [online]. 31 December 2009 [cit. 2010-08-06]. How Is Consumer-Directed Health Care Supposed to Reduce Health Spending?. Available at: <http://healthinsurance.about.com/od/faqs/f/cdhsave.htm>.

decisions regarding health care themselves. Centralizers are skeptic when it comes to people´s ability to make informed decisions about health care and rather adopt elite-made central health care policies applying to all without exception. CDHC intensifies the power of individual preference and decision making, but is balanced by some form of regulation ensuring stability and security. Patients make decisions about routine, inexpensive care, but more expensive, specialized health care management is left with the professionals. Patients using CDHC accounts are spending their own money and naturally try to save as much as possible by making prudent choices. After a decade of CDHC plans' existence, the plans actually proved that they are very strong mechanisms to achieve lower cost health care without sacrificing quality. While all other health plans premiums increased, the CDHC health plans saved on average 12 to 20 %. The prophecies of people trying to save so much that they would ignore preventive care were not fulfilled. On the contrary, the number of preventive health care services significantly increased proving that people are capable of making informed decisions without heavy regulation limiting their choices. The 2010 health care reform law however brings some big regulatory changes into the CDHC management and thus some experts worry about the CDHC plans´ "death by regulation". [123]

[123] SUDERMAN, Peter. Reason.com : free minds and free markets [online]. 28 May 2010 [cit. 2010-08-09]. The Rise of Consumer Driven Care. Available at: <http://reason.com/archives/2010/05/28/the-rise-of-consumer-driven-ca>.

4. PRIVATE HEALTH INSURANCE

Private health insurance is the primary source of health coverage for most Americans. There are two basic types of private health insurance: individual health insurance and group health insurance. The most common group health insurance is acquired through employer (i.e. employer-sponsored health insurance) as part of the employment benefit package. College-sponsored health insurance and health insurance for federal employees are also group health insurances. Large associations, such as the American Bar Association, offer association group health coverage. Persons who do not qualify for group health insurance may purchase individual health insurance from any insurance company offering individual health insurance plans. [124]

In this chapter we first discuss private health insurance regulation and basic elements of health insurance relationship. Later, essential attributes of each type of private health insurance are presented.

4. 1 Private Health Insurance Relationship [125]

The health insurance relationship is a contract under which the insured pays periodic premiums to a health insurance company at one point of time with the understanding that if certain losses described in the contract eventuate at a later point in time, the health insurer will cover the expenses for provided health care.

The relationship is problematic in several ways. First, its viability completely depends on the financial capacity and security of the insurer. Second, the insured must rely on the insurer´s fair policies and payments of claims. Third, the insurance contract is what we call an "adhesion contract". It is drafted by the insurer and almost closed for any changes that an insured may propose. The insured heavily relies on the assurance of

[124] Health insurance in the United States#Employer-sponsored. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 21 January 2008, last modified on 26 July 2010 [cit. 2010-08-09]. Available at: <http://en.wikipedia.org/wiki/Health_insurance_in_the_United_States#Employer-sponsored>.

[125] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at: < http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

insurer that the contract meets all the client´s needs and will reimburse the health care costs if they occur. Finally, the insured largely depends on the marketing, business and investment practices of the insurer. The economic concepts of adverse selection and moral hazard further complicate the relationship.

Adverse selection centers on the information asymmetry between the insurer and the applicant for health insurance, meaning that the applicant for insurance knows more about the nature of risks that may eventuate on his/her side than the insurer will ever know. Here it is the insurer who is vulnerable. Thus the insurer expects people who think of themselves as more pertinent to health risk to purchase more complete health coverage than the people who perceive themselves as low-risk. The insurer consequently charges higher premiums for more comprehensive health coverage not for the higher cost of the benefits contained, but for the prerogative that its purchasers are higher risk applicants according to the adverse selection theory. This is the point where regulators and insurance companies dissent. The regulators operate on the premises that the price of a health coverage premium arises only out of the number of benefits contained and has no association whatsoever with the adverse selection. Insurers, on the other hand, actually accept the adverse selection theory and thus charge higher premiums on more comprehensive coverage and assess carefully the applicants with regard to the risks they pertain. As a result, people with pre-existing conditions may be denied health care coverage and more risky applicants must accept higher premiums. Regulators respond by limiting the insurers in charging different premiums based on these factors and some states even prohibit these practices [126]. The health care reform of 2010 limits these processes further on a federal level.

Moral hazard refers to the theory that once a risk is insured, it is more likely to occur. Under moral hazard theory, for example an insured driver drives less carefully than uninsured driver. The moral hazard, taken to extreme levels, results in fraudulent claims submitted to health insurers with the aim to receive some kind of reimbursement for completely intentional risky behavior.

Furthermore, health insurance poses its own additional issues. One of the main problems is the difficulty to define the coverage and scope of health insurance contract. There are so many products on the market that it is rather impossible to completely

[126] these practices are known as “favorable selection” or “cherry picking”

enumerate what is covered and what is excluded. Generally, most insurance contracts contain terms such as "medically necessary services" to express the health coverage. As you can imagine, many disputes then arise since a lot of entities may have different opinions on what is medically necessary. Another issue is that the applicants for insurance tend to "under-insure", because they do not realize the full scope of possible health problems. From the economic point of view, health insurance market operates unlike any other market. In most markets, sellers wish to have as many customers as possible, thus stretching the demand to sell high volumes of their products. In the health insurance market, the insurance companies pre-select their "customers" and offer their products only to those who are the most likely to need the least expensive health care, while denying the other possible customers. This is partially because of the state and federal legislation prohibiting the insurers to charge different premiums according to health care status. Since the insurers cannot issue higher charges on those with pre-existing medical conditions, they will simply deny them the insurance as a whole. Most insurance companies also rely upon the fact that if they offer hassle-free primary and preventive care coverage (e.g. free doctor visits, prescription drugs), the insured will be satisfied enough to endure inferior services in specialized care coverage (e.g. coverage limits for organ transplants), since only a limited number of the insured will use these specialized services anyway.

Some serious problems are associated with the U.S. health insurance market. First, most Americans receive employer-sponsored health coverage or government health coverage. Although ultimately all health insurance is paid by the individuals, people are not aware of the actual costs of health insurance and its distribution. Government programs are financed through taxes that shorten the disposable income of the individuals. But to most people, it seems as if the government health coverage is free. Same goes with the employer-sponsored health insurance. It also reduces the employees´ wages, though indirectly through deductions of contributions directly off their paychecks. Tax subsidies of health insurance contribution further add to inattentiveness to real health care costs. As a result, moral hazard occurs in full power in these two main types of health insurance.

Even though the moral hazard is at its highest in the employer-sponsored health coverage, this type of insurance still provides significant advantages. Insured employees

benefit from economies of scale and the insurance companies from the relatively healthy insureds (adverse selection is much lower since employees are fit enough to work). On the other hand, main disadvantages arise out the fact that employers themselves purchase the health insurance and thus the type of health plan does not have to reflect the individual employees´ wishes. Further, employers will more likely purchase cheaper health coverage, because they are not the ones that will encounter the difficulties of claims processing. Most employees never actually see their insurance contract and rely upon the information from the employer. Last, employer-sponsored health coverage is entirely dependent on the existence of the particular employment contract. People who lose jobs are all of a sudden uninsured. Newer regulations, especially the ones associated with health care reform, however do avoid this happening by setting some form of grace period to cover the insured in between the searches for a different job.

Another problem associated with health insurance is the inability of patients to determine, once in physician´s hands, what procedures are necessary and how much they cost. Physicians must follow own rules in respect of what kinds of tests are needed for a particular diagnosis and do not cross-check whether that particular test falls within the scope of health coverage of an individual´s insurance.

Finally, health insurance market is unusual due to different nature of health care or health insurance in contrast with other commodities. In most countries around the world, health care or health coverage is mainly looked at as a right, not as a business commodity such as car insurance, and is publicly insured. In the U.S., public insurance covers a large amount of population, but the individual market perceives health care as a regular purchasable commodity. Objective economic judgments of both approaches are rather difficult and as usual, the compromise between two radical approaches is probably the best.

4. 2 Private Health Insurance Governance and Regulation

4. 2. 1 Private Health Insurance Governance [127]

There are various approaches to governing health insurance. For example, health insurance market may be left completely unregulated, thus operating only under the rules of economy. The insurer and the insured would negotiate the terms of the insurance contracts themselves, without any limitations. The judiciary would resolve the disputes using the contract law, probably with some respect to consumer protection.

Lawsuits claiming breach of health insurance contract are very common in the U.S. Since courts know the insurance contracts are drafted by insurers only, they balance this inequality through the common law doctrine of "contra proferentem". Under this doctrine, the ambiguous provisions or terms of the contracts are interpreted in favor of the party that has not imposed it (i.e. the insured). Hence this doctrine gives benefit to the party upon whom the adhesion contract has been foisted and no additional government regulation is necessary.

Another approach to governing private health insurance centers on private litigation alleging the breach of general consumer protections laws (e.g. unfair claim settlement practices). Consumer protection laws provide the minimum regulation of health insurance contracts with individuals. Private litigation, however, has severe limitations, such as the cost and time consumption. In addition, insurers are used to litigations and know how to control the litigation process better than first time litigators. As a result, both federal and state government started to require that health insurers offer alternative dispute resolution mechanisms, such as internal reviews or mediation. Virtually all states also provide for external review of claims denials.

Private health insurance market could be left without government interference only if no fraud and abuse existed. Private dispute resolutions are able to take care of rights of the insured, but are no match for fraud and abuse in the insurance industry. Therefore, government must intervene and for example prevent the insurers from providing bogus and scam health insurance policies.

[127] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

Health insurance regulation and governance is traditionally characterized by overlapping roles of the federal government, state governments and the judiciary. States license the insurance entities, but federal laws have an impact as well. While some states wait until a particular statute is violated to take enforcement actions, others provide for extended regulation prior to granting a license enabling entry to the health insurance market, such as ensuring compliance with laws [128] or fulfillment of financial requirements. [129]

4. 2. 2 Federal Private Health Insurance Regulation [130]

Private health insurance regulation is divided between states and federal government. The grounds for the federal regulation of health insurance were set in the Supreme Court case *United States v South-Eastern Underwriters Association* (1944). Before this decision, the issuance of insurance policies had not been considered a transaction of commerce, and therefore the Court ruled consistently (since *Paul v Virginia,* 1869) that insurance did not constitute interstate commerce. As a result, the federal government had no authorization in limiting the policies and all matters were left to states, even if the insurance companies went across states. In the U.S. v South-Eastern Underwriters Association, the federal Department of Justice filed a lawsuit against the South-Eastern Underwriters Association for the violation of the SAA for price-fixing of premiums for fire insurance. The Court finally held that the company conducting substantial parts of its business across state lines was engaged in interstate commerce and that the federal government could regulate such insurance companies under the commerce clause of the Constitution. The Congress immediately passed the McCarran-Fergusson Act in 1945, which restored the primary state regulation of the insurance business by exempting the business of insurance companies from most federal regulation setting the principle that unless specifically purported in an Act, most federal laws do not apply to the business of insurance and states may regulate the insurance

[128] insurance products must comply e.g. with contract, tort or social policy laws of each state in addition to health care and health insurance laws

[129] NAIC : National Association of Insurance Commissioners [online]. 2009 [cit. 2010-08-09]. Proposed Federal Insurance Regulation. Available at: <http://www.naic.org/topics/topic_federal_insurance_regulator.htm>.

[130] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

business themselves. [131] After that, federal authorities withdrew themselves from the health insurance market until 1954, when the IRC established that the employer contributions to employees´ health insurance were not taxable. As a result, the employment-sponsored health insurance expanded and now covers about 60 % of Americans. Subsequent laws extended tax subsidies to cover health insurance premiums of self-employed and funds in health saving accounts. In 1965, Congress established two public health insurance programs, Medicare and Medicaid. Medicare is financed exclusively through federal government and any state law conflicting with Medicare program requirements is generally preempted by the federal law. Medicaid, on the other hand, is funded by both state and federal governments and administered by state agencies that are subject to federal laws. Medicaid operates through Medicare-licensed managed care organizations.

The most important intervention of the federal government in the health insurance market was the Employee Retirement Income Security Act of 1974 (ERISA). It applies primarily to pension law, but some provisions regulate employees´ health benefits. Section 514 provides that the ERISA "shall supersede any and all State laws that relate to any employee benefit plan". This provision intended to allow employers that operate in several states to offer benefit plans on a national basis and do not adjust the plan according to individual states. However, as in all laws, there are number of exemptions and particularly section 514 (b)(2)(A) is important since it saves "state laws that regulate insurers" from preemption. Consequently, states are actually free to impose any regulatory requirements on health insurers that sell their plans to employers, and these requirements naturally vary. To make things more complicated, there is also exception to this exception in section 514 (b)(2)(B) of the ERISA. Under this provision, "states are not permitted to deem employee benefit plans themselves to be insurers". This means that states cannot impose duty on employers to offer one particular benefit and also cannot regulate at all the self-insured plans of employers. [132] States thus cannot

[131] Answers.com : US Supreme Court [online]. 2005 [cit. 2010-08-04]. United States v. South-eastern Underwriters Association. Available at: <http://www.answers.com/topic/united-states-v-south-eastern-underwriters-association>.

[132] Self-insurance describes the situation where employers themselves bear the risks associated with health insurance rather than purchasing health insurance from an insurance company. Employers who self-insure or self-fund provide

extend insurance coverage to those people covered by self-insured employers [133] and if they try to impose comprehensive health coverage benefits on those whom they may regulate, the employers move towards self-insurance and escape the regulation anyhow. Preemption provisions contain many exceptions, and thus the consequences of their interaction tend to be quite bizarre. For example, states can adopt laws affecting benefit coverage as long as the effect is rather indirect. Also, they can enforce hospital rate regulations that will charge more to self-insured health plans than to Blue Cross plans. But they are not permitted to require employers to provide health insurance. They may also not impose any obligations on self-insured employers. But the employers that purchase health insurance on the market and do not self-insure may be subjected to virtually any health coverage requirement from states. ERISA does not contain any coverage mandates [134].

Other federal government regulation includes the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which enables some employees who lose employment-sponsored health insurance due to qualifying events, such as termination of employment or reduction of work hours, to keep their health coverage for up to 36 months by paying 102 % of the premium cost. This is one of the most costly mandates out of all, both states and federal. COBRA of 1986 regulated the continuation requirements on federal level for the first time, but before that, many states have enacted similar laws.

In 1996, the HIPAA was introduced as an initial step towards federal health coverage mandates. It limits the ability of insurers to engage in risky practices and prohibits employment related group health plans from discriminating on the basis of health care status. Moreover, it imposes three limits on the use of pre-existing condition clauses by: (1) defining the pre-existing condition; (2) limiting the look-back period for determining whether a health condition exists to six months; and (3) permitting the pre-existing condition clause to operate for a maximum period of twelve months. Further,

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and operate their own health insurance plans. Employers then usually reinsure themselves with some well established reinsurance company.

[133] e.g. state of Maryland was prohibited to require that Wal-Mart spends 8 % of its payroll on health benefits in Retail Industry Leaders Ass´ v Fielder, because it would violate the ERISA

[134] laws enacting which benefits, health care services and health care providers must be included in and covered by certain health insurance plans

HIPAA requires that small group insurers guarantee both "issue" and "renewability" and individual insurers guarantee at least renewal. [135] Under certain conditions, individual health insurers must offer non-group health coverage to a person who has lost its group health coverage in states where no alternative health insurance options for these cases exist (e.g. there are no state risk-pools). [136]

Congress itself participates in issuing coverage mandates. Federal health mandates often lay requirements for state mandates. The federal law does not require the employers to offer a health insurance coverage, however, if they choose to provide health coverage (under state laws), the federal mandates force them to cover for certain benefits. As do the state mandates, because states will adopt rules that oblige the insurers to meet the requirements set by federal government. For example, federal mandates require that all insurance plans cover 48 hours of inpatient hospitalization after normal child delivery (96 hours for Cesarean section), or that breast reconstruction is included in all health plans covering mastectomies. The Mental Health Parity and Addiction Equity Act (prohibits setting annual or life-time limits for mental health coverage that are less generous than those applying to physical health coverage, and requires benefits for treatment of substance abuse) and so called Michelle´s Law (obliges continuation of health insurance for full time college students on medical leave of absence) are other examples of federal mandates.

Other federal laws affecting the health insurance are the Age Discrimination in Employment Act, prohibiting employers in offering heath insurance of different values to different age groups; the Pregnancy Discrimination Act, requiring that employer-sponsored health insurance plans cover pregnancy and childbirth related services; the Americans with Disabilities Act prohibiting intentional discrimination of disabled when offering health insurance; the Newborns' and Mothers' Health Protection Act and the Women's Health and Cancer Rights Act. [137]

[135] "guaranteed issue" laws prohibit insurers from denying health insurance to applicants based on their health status; "guaranteed renewability" laws prohibit insurers from cancelling coverage upon submission of medical claims for reimbursement or upon diagnosis of a certain illness

[136] see chapter 4.6.2

[137] U.S. Department of Health and Human Services. THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET [online]. [s.l.] : [s.n.], Winter 2008 [cit. 2010-08-05]. Available at: <http://aspe.hhs.gov/health/reports/08/reginsure/report.pdf>.

Federal government also adopts accounting and financial solvency related legislation. For example in 1999, the Gramm-Leach-Bliley Act (GLBA) modernized federal financial supervision laws and repealed part of the Glass-Steagall Act of 1933. The Glass-Steagall Act prohibited any institution from acting as a combination of an investment bank, a commercial (depository) bank and an insurance company. The GLBA allowed consolidations and mergers of any combination thereof. The combined industry is now known as the "financial services" industry. President Barrack Obama and some other experts, mostly economists, believe that the GLBA contributed to the development of recent financial crisis. The proponents of the GLBA argue that the consolidated institutions on the contrary proved to be more stable during the crisis. [138] An example of legislation associated with accounting of insurance is the Fair Credit Reporting Act.

Recently, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) were passed as the base for the nation´s health care reform. This constitutes a huge step towards universal health care and definitely one of the most significant pieces of the U.S. federal legislation. The final chapter of this paper deals with the health care reform.

4. 2. 3 State Private Health Insurance Regulation [139]

Health insurance is a recent phenomenon in the U.S. Eighty years ago no health insurance concept even existed. By the time the health insurance market started to expand, states claimed the jurisdiction over the health insurance market. The jurisdiction was confirmed by the Supreme Court in *Paul v. Virginia*, where it ruled that the insurance was not an interstate commerce and thus not subject to federal control. However, in 1944 the Supreme Court ruled differently in the *United States v. South-Eastern Underwriters Association*, and the federal government could, under certain conditions, regulate the insurance market based on the interstate commerce clause from the Constitution. In response, Congress adopted McCarran-Fergusson Act, by which it

[138] Gramm-Leach-Bliley Act. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 2 January 2003, last modified on 28 July 2010 [cit. 2010-08-05]. Available at: <http://en.wikipedia.org/wiki/Gramm-Leach-Bliley_Act>.

[139] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at: < http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

returned the power to regulate health insurance market to states, unless Congress explicitly said otherwise. The federal government kept the promise to leave the entire insurance regulation to states for about 10 more years until 1954, when the occasional federal interventions returned.

State regulation has been coordinated by the National Association of Insurance Commissioners (NAIC), an ambiguous status company (in part public, in part private) depending on fees paid by insurance companies. NAIC forms templates and models for efficient state law regulation of insurance market and thus brings a certain level of uniformity to state regulation, which would otherwise differ from state to state. NAIC provides some general guidelines for states´ legislation, but unless enacted, these rules have no law force. However, several model laws have been enacted into positive law by states, these include: the Uniform Individual Accident and Sickness Policy Provision Law, the Accident and Sickness Insurance Minimum Standards Model Act, the Advertisements of Accident and Sickness Insurance Model Regulation or the Unfair Trade Practices Act.

From the beginning of health insurance regulation, states focused on the financial responsibility and solvency of the insurers. Insurers must first meet capitalization and reserve requirements to obtain a license, and then regularly file audited financial reports and tolerate on-site exams from state departments to keep the license. The federal Bankruptcy Code expressly excluded insurance companies from its scope; therefore states must handle insolvencies of insurance companies on their own. States often create separate solvency guarantee fund to cover the obligations of insurers that become insolvent. Traditionally, states also required insurers to file health insurance policies with the insurance departments and implement some standard provisions in their contract; however they did not approve these policies in general, rather in individual cases only when a policy was clearly “unjust, unfair, inequitable or misleading”. In the past, states also imposed taxes on collected premiums. Overall, the insurers used to be quite free to conduct their business once they fulfilled the duties above.

From the start, Blue Cross and Blue Shield plans did not need to meet the requirements for regular insurance companies since they operated on the non-profit basis. On the contrary, states adopted several acts that reduced financial and other

obligations for these plans. In exchange, these plans must have complied with "public service requirements" (e.g. their health plans benefits were subject to states´ approvals) and for a time they functioned as public insurers, offering open enrollment and community rated premiums. Number of states required these plans to provide a completely free choice of medical providers or to obtain a state approval for their reimbursement plans prior to their marketing. Some states event approved the rating of premiums.

In respect of the content of health care coverage, no requirements were set until mid 1950s. Starting the 1950s, states began to prohibit health insurance policies that were "of no real economic value". Later, minimum scopes of coverage and limits in cancelling and renewing health policies were introduced. In the 1970s, "state health coverage mandates" started to appear.

A health insurance mandate is a requirement that a health plan or an insurance company covers common health care providers, benefits and population. The first mandates were laws requiring that health insurance policy covers newborn children of the insured. These mandates were enacted into positive law by 1980 in all states. Other common mandates included coverage of handicapped dependents, services of optometrists, psychologists and chiropractors, and alcohol abuse treatment. Current mandates require coverage for services of chiropractors, midwifes or massage therapists among health care providers, payment for mammograms, child care, acupuncture, insuring adopted and foster care children, minimum maternity stay, obesity care etc. There is a demand for every health care service or product that exists. The state mandates ensure that those in need of the services will have health plans that cover their needs to choose from. Further, some proponents believe that assuring the availability of public goods prevents negative externalities. For example, vaccine coverage mandates ensure that most people will get vaccinated and common diseases disappear. On the other hand, health insurance mandates enacting the companies what health services to cover increase the cost of basic health care by approximately 20 %. As a result, those who cannot afford these comprehensive health plans remain uninsured because they have trouble finding cheaper, less comprehensive health plans on the market as those would not meet the state mandates. HDHPs present one option, but the fear of deductibles may keep many people from purchasing the plan. So why is the number of

state mandates and the amount of health insurance still rising? The number one reason is that it is simply just too hard to oppose legislation that offers more health coverage to the people (i.e. voters). The government control of health insurance market then rapidly increases and so does the cost of health care plans. Today, about 2,133 mandates exist on the health insurance market. All but two states impose more than 20 mandates at the same time.

As noted above, state mandates do not apply to self-insuring employers according to ERISA. Logically, the employers try to minimize the health insurance costs and will rather self-insure than buy expensive health insurance on the market. Sadly, self-insuring is constantly proving its insufficiency, high cost and ineffectiveness. After some time, employers who self-insure tend to drop the insurance benefit and increase the number of uninsured.

Not only mandates add to the costs of health insurance. Some states adopted legislation that requires insurance companies that sell their health plans on the individual market (not through employer) to accept anyone who applies, regardless their health ("guaranteed issue policy"). Some states even limit the health insurers in pricing the premiums according to one´s health status. This system, called "community rating", is obligatory in public health insurance programs, but some states apply its limited form even to commercial insurers. [140]

States differentiate the health insurance regulation between large groups (more than 50 members), small groups (less than 50 member but more than 3 members) and non-group markets (individual health insurance). Large group health insurance operates relatively well, while small group and non-group markets tend to struggle. Virtually all large employers offer health benefits to their employees. Small employers on the other hand do not. Small group market does not attract the insurers, because small group present higher risk profiles and adverse selection. These problems intensify on the individual health insurance market. Insurers must spend more time and cost on calculating the risks and figuring out the way how to eliminate them, which makes the small group health insurance price significantly higher.

[140] CRAIG BUNCE, Victoria. Health Insurance Mandates in the States 2009 [online]. Alexandria, VA, USA : The Council for Affordable Health Insurance, 2009 [cit. 2010-08-03]. Available at: <http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf>.

In the 1990s, states started to enact small group insurance reforms. The most common were "guaranteed issue", "guaranteed renewal" and "no pre-existing condition discrimination" laws. In 1996, all of these laws were adopted at federal level in the HIPAA. Some states oblige community rating health insurance policies, where all insured must pay the same premiums regardless their health status, geographical location and other. However, most states allow variance based on age.

Many states have also adopted individual health insurance market reforms, but due to volatility of this market, there are concerns that aggressive state regulation could essentially destroy the whole segment. Insurers do not particularly oppose the states´ efforts (they just continue to raise the premium prices accordingly), but economists and free market advocates are frustrated with the extending state intervention.

The business entities on the health insurance market are very creative when it comes to escaping regulation. For example, small entities form a small business association, which then offers beneficiary health insurance to its members and because there are more members altogether than in the individual companies that associated, they escape the small group market regulation. Consequently, the association health plans are more frequently found fraudulent or violating the laws than any other forms of health insurance.

Recent health insurance legislation has been trying to correct the flaws in health insurance market. For example in 2003, the Medicare Modernization Act was adopted on federal level and among other things authorized tax subsidies for HSAs coupled with HDHPs. The Act did not preempt state laws, but tax subsidies established in this Act would only apply in states that permitted HDHPs on their markets. Some states had laws that limited the sale of these plans, thus they had to repeal these conflicting laws to enable the consumers to benefit from tax subsidies.

4. 3 Employer-sponsored Health Insurance [141]

Employer-sponsored health insurance represents more than 90 % of the private insurance market and provides health coverage for approximately 159 million

[141] The Kaiser Family Foundation. Employer Health Benefits : 2009 Annual Survey [online]. USA : [s.n.], 2009 [cit. 2010-08-09]. Available at: <http://ehbs.kff.org/?CFID=31322907&CFTOKEN=27594448&jsessionid=60303a3e8e0b477b269186a607811284b7f2>. ISBN 978-0-87258-864-6.

Americans. Almost all large employers offer group health insurance programs for their employees and their families. Many studies proved that the employees with health insurance are more productive at work (due to regular health care checkups and early treatments) when compared to the employees without health insurance. Health insurance benefit is completely voluntary; employees choose either to enroll or to forgo the offer. It is not uncommon that the Americans choose the job based on its health coverage plan. Health insurance benefits enjoy tax subsidies (under certain conditions) and therefore constitute a good bargain for both an employee and an employer. Further, employer-sponsored health coverage is far less expensive than any other form of private health insurance due to economies of scale and offers a wide variety of health care benefits. In 2009, 60 % of employers were offering health coverage. From 2014 and on, following the health care reform, a fine of $ 2000 per employee will be imposed on employers with more than 50 employees who do not offer health coverage plan. [142]

In most cases, an employee needs to work full-time for a certain time limit before becoming eligible for employer-sponsored health insurance. Once enrolled in, he/she needs to keep the full-time employment and contribute to the insurance premium payment to receive the benefit. Employers contribute significantly to the payment of insurance premiums. [143] In 2009, the average annual premium for health insurance was $ 4,284 for single employee coverage and $ 13,375 for family coverage. Employees contributed only 17 % (single coverage) or 27 % (family coverage) of the premium cost, while employers paid the rest. 18 % of workers even enjoy no-employee contribution health insurance where the employer bears all costs.

Even though employer-sponsored health insurance ranks among cheaper health coverage due to employers´ contribution, health insurance expenses of employers have been growing so much recently they are predicted to overtake profits in the future unless some drastic changes happen. Since 1999 the employer-sponsored health insurance premiums went up 120 %, which corresponds to the approximate payment of $ 1,600 more annually. The health insurance premiums have risen four times faster than employees´ earnings over the respective period. Employers mostly offer managed care

[142] in 2008, about 95 % of employers with more than 50 employees were offering some kind of health insurance

[143] STANTON, Mark W. Employer-Sponsored Health Insurance: Trends in Cost and Access [online]. Rocvillle, MD, USA : [s.n.], September 2004 [cit. 2010-08-09]. Available at: <http://www.ahrq.gov/research/empspria/empspria.pdf>.

plans since they can be purchased for reasonable price. 60 % of workers were enrolled in PPOs in 2009. 20 % of workers had HMO plans, 10 % used POSs, 8 % owned HDHP and 2 % had conventional, fee-for-service plan. About 86 % of employers provide only one choice of health plan for all employees.

As mentioned above, the employer does not yet have the obligation to provide health benefits to its employees. However, once a health coverage plan is presented, the employer must comply with enormous amount of rules, regulations and laws regulating health benefits. Since the employers already have to comply with both federal and state labor laws, anti-discriminatory laws, anti-trust laws etc., adding the obligation to act in accordance with the health insurance plans regulation creates a complete legal maze. To get the idea of the complexity of regulations, here is a portion of some major laws related to provision of health benefits by employers that the employer must comply with: [144] [145]

the Employee Retirement Income Security Act of 1974 (ERISA)	ERISA primarily regulates pension plans management, but contains provisions that apply to health benefits as well. Under ERISA, employers must e.g. notify employees of all changes to the health plan and manage the health plan funds to the best interests of employees.
the American Recovery and Reinvestment Act of 2009 (ARRA)	Amends HIPAA and COBRA Acts: Under COBRA, an individual may keep employment based health coverage even after losing employment for up to 18 months by paying 102 % of the premium price. ARRA provides that the federal government pays 65 % of the COBRA premium price for the employees for up to 9 months in case of involuntary layoffs occurred within certain period. Further, ARRA expands privacy and security regulations

[144] FindLaw [online]. 2010 [cit. 2010-08-09]. Health Insurance Overview. Available at: <http://smallbusiness.findlaw.com/employment-employer/employment-employer-benefits/employment-employer-benefits-health-insurance.html>.

[145] HRHero.com : Your Employment Law Resource [online]. 2009 [cit. 2010-08-09]. Employer Health Insurance Plans and Employment Law . Available at: <http://www.hrhero.com/topics/health_benefits.html>.

	associated with HIPAA.
the Family and Medical Leave Act of 1993 (FMLA) [146]	FMLA allows eligible employees to take up to 12 workweeks of unpaid leave during any 12 month period for specified reasons, e.g. to care for newborn or adopted child, to care for a spouse with a serious health condition, to obtain treatment for own health condition etc. FMLA was passed due to an increasing number of single parent families who in case of a serious illness or birth of a child had to choose between keeping the job or providing care to a family member.
section 125 of the IRC of 1986 (Cafeteria plan)	Cafeteria plan is a collection of benefits for employees including health insurance that is free of payroll tax if provided to the employees. The section 125 lists the benefits eligible for the tax exempt status (e.g. health coverage, group life insurance)
the Medicare Modernization Act of 2003 (MMA)	MMA adopted major changes in the Medicare program, including creation of prescription drug benefit under Medicare.
the Mental Health Parity and Addiction Equity Act of 1996 (MHPA)	MHPA requires that no health care plan provides lower coverage on mental health problems than on other surgical or medical problems
the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)	USERRA is a federal law ensuring that the persons who serve/have served in the Armed Forces, National Guard or other uniformed services are not disadvantaged or discriminated in their civilian jobs based on their military service duties [147]
laws banning discrimination in employment relations (health coverage included): the Age Discrimination in Employment Act; the Americans with Disabilities Act; Title VII	As with other areas of employment (hiring, promoting, terminating), any discriminatory behavior on any basis (gender, race, age, religion, disability) is strictly prohibited. Therefore, an employer may not, among other things, provide lesser health coverage to old workers, treat pregnancy-related disabilities (abortion, post-childbirth delivery) differently from other health conditions or refuse to provide health coverage to temporarily disabled employees.

[146] Answers.com : Major Acts of Congress [online].Gale Group Inc., 2004 [cit. 2010-08-09]. Family and Medical Leave Act of 1993. Available at: <http://www.answers.com/topic/family-and-medical-leave-act-of-1993>.
[147] U.S. Office of Special Council [online]. 2010 [cit. 2010-08-09]. About USERRA. Available at: <http://www.osc.gov/userraOverview.htm>.

of the Civil Rights Act of 1964, and the Equal Pay Act	
state and federal coverage mandates	

4. 4 Federal Employees Health Benefit Plan (FEHBP) [148] [149]

The federal government has been sponsoring a health insurance plan for its civilian employees since 1960. Military service employees are covered directly through the Department of Defense Military Health System. The FEHBP program is administered by the U.S. Office for Personnel Management. Federal employees have access to the largest selection of health care plans in the U.S. There is a wide selection of available plans separately for each of fifty states, aggregating to total amount of 250 health plans. About 20 plans are nation-wide, such as Blue Cross and Blue Shield health plans, other plans are only locally available. For example, the residents of Pennsylvania may choose from 26 different health plans. Eligibility for some plans depends on certain conditions, such as permanent residency in the area or required periodic medical exams, while other plans are open to any federal employee. The variety of plans corresponds to the variety of federal employees. Congressmen as well as postal workers are all federal employees and thus covered by FEHBP. The number of provided health plans allows each individual to choose the health plan with the best coverage. The government pays up to 75 % of the premium price on behalf of its employees. Federal employees with strong union support (such as the noted postal workers) pay less due to the power of collective bargaining.

Federal government sets only minimal requirements and conditions for the health plans (or more precisely, the insurance companies providing health plans) to participate in the FEHBP. This causes large competition of individual health coverage plans on the FEHBP market from which the employees profit (lower premiums, better benefits). The 2010 annual premiums range from $ 2,800 to $ 7,200.

[148] U.S. Office of Personnel Management [online]. 2010 [cit. 2010-08-08]. Federal Employees Health Benefits Program. Available at: <http://www.opm.gov/insure/health/>.

[149] Federal Employees Health Benefits Program. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 9 November 2004, last modified on 24 July 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Federal_Employees_Health_Benefits_Program>

A federal employee may enroll in any plan of his/her choice (if eligible) in the so called open enrollment period. The open enrollment period takes place annually and lasts about a month. For 2010, the period starts on 8 November and ends on 13 December of 2010. The open enrollment period is significant for anyone wishing to enroll, change or cancel the health plan. During this period, the employees may freely enroll, change or cancel any offered health plan regardless the previous health plan´s limiting conditions concerning termination, transfer etc. After the enrollment period, only changes due to "qualifying life event" (birth of a child, divorce) are allowed.

The FEHBP statute regulating the whole program is only a few dozen pages long. In contrast, Medicare Act is about 400 pages long and accompanying regulation adds another thousand pages. There is a debate that the FEHBP system could actually work as a universal health system for all Americans. In 2004, it was actually proposed by Senator John Kerry. Later, the Wyden-Benet Act, representing a failed attempt for health care reform in 2008, was created based on the FEHPB system. The intention was to create compulsory health insurance for all Americans paid from both private and public funds. The bill is also known as the Healthy Americans Act after the name of the compulsory health plans, which were called "Healthy Americans Private Insurance Plans or HAPIs". The act among others promised to "*guarantee private health care coverage for all Americans…with the benefits now available only to members of Congress*". [150] Instead, the PPACA was passed as the basis of health care reform.

4. 5 Other Types of Group Health Insurance

Other forms of group health insurance include association group health insurance for the members of certain associations and college-sponsored health insurance.

Associations offer group health insurance coverage for its members, usually through a well known private insurance company. Association-sponsored health insurance is the alternative for the individuals who do not qualify for employer-sponsored health insurance and do not want to buy individual health plans. If they are members of certain association, they may be eligible for group health insurance plan

[150] United States Senator Ron Wyden [online]. 2010 [cit. 2010-08-08]. The Healthy Americans Act. Available at: <http://wyden.senate.gov/issues/legislation/details/?id=27248423-2e83-463b-ae03-a11fe572837f>.

underwritten by the association. Individuals thus get the savings characteristic for group health insurance while keeping the individual insurance health plan flexibility. The associations may be career-related, such as the American Bar Association, hobby-related or social status-related. One of the oldest associations is the AARP (formerly known as the American Association for the Retired Persons) for the people aged 50 years and over. Members (annual payment is required) receive variety of benefits for (sometimes) discounted price, one of them being Medicare supplementary health coverage insurance. As with any other non-profit health insurance providers, state and federal rules apply. NAIC provided model guidelines for state regulation of association health insurance, e.g. association must have at least 100 members to be able to arrange health insurance. Associations do not self-insure, but use a well established health insurance company. Some associations are very close to medical care providers and thus must pay great attention to anti-referral fraud and abuse laws. [151] [152]

Most universities and colleges provide school-sponsored health insurance plans for their students. Usually, if a student does not prove other health coverage plan (parent´s health insurance), he/she must enroll in the school health insurance plan. The premiums tend to be affordable, but often there are strict coverage limitations, such as the obligation to visit only one particular medical facility near the school area. Graduate students are usually eligible for health coverage with additional benefits, such as cross-state health coverage. Some schools even sponsor their alumni. [153]

[151] MATTHEWS, Merryl. The Heartland Institute : Free market solutions [online]. 1 February 2003 [cit. 2010-08-08]. Association Group Health Insurance Sparks Controversy. Available at: <http://www.heartland.org/policybot/results/11514/Association_Group_Health_Insurance_Sparks_Controversy.html>.

[152] Health insurance in the United States. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 21 January 2008, last modified on 26 July 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Health_insurance_in_the_United_States>.

[153] CollegeHealthInsurance.org [online]. 2010 [cit. 2010-08-04]. College Health Insurance. Available at: <http://collegehealthinsurance.org/>.

4. 6 Individual Health Insurance [154] [155]

4. 6. 1 Basic Characteristics

About 9 % of Americans have non-group individual health insurance. Individual health insurance targets people without access to group-sponsored or public health insurance. The range of products is similar to those in employer-sponsored plans, but because they lack the group element, they are generally more expensive, with higher deductibles/co-payments/co-insurances and with fewer tax benefits. On the other hand, the health plans on the private insurance market are much more personalized and more likely to meet each individual´s needs.

Individuals have to pay the premiums without any contributions from a third party, unlike in employer-sponsored health plans. Currently, premiums differ significantly for different groups. Starting 2014, when the provisions of health care reform regulations come fully into effect, the private insurers will be prohibited to charge higher rates based on pre-existing health conditions.

There are many types of health insurance plans present on the individual health insurance market. Traditional managed care plans are still very popular, but mixed plans and "low-cost" plans (e.g. HDHPs) are slowly taking over. Apart from standard health insurance plans, individuals may purchase "mini-medical" health insurance. This type of insurance reimburses the individual by paying certain fees for services directly to the individual, however sometimes very limited, e.g. $ 40 for a doctor´s visit (the actual price the individual pays for the doctor´s visit is much higher). Mini-medical plans are low-cost option to the major medical plans and may also be purchased as an additional supplementary plan to reimburse for high deductibles paid under major medical plans.

Not all plans are long term. The market also offers short term coverage used for example by the people in between jobs or during waiting period before they become eligible for employer-sponsored health coverage. Short term individual health plans usually do not cover preventive care, but instead focus on reimbursement in the case of

[154] U.S. Department of Health and Human Services. THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET [online]. [s.l.] : [s.n.], Winter 2008 [cit. 2010-08-09]. Available at: <http://aspe.hhs.gov/health/reports/08/reginsure/report.pdf>.

[155] Individually purchased health insurance in the United States. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 27 March 2010, last modified on 21 June 2010 [cit. 2010-08-11]. Available at: <http://en.wikipedia.org/wiki/Individually_purchased_health_insurance_in_the_United_States>.

accidental illnesses or injuries. The individual health insurance market offers a variety of additional health coverage plans, such as disability insurance, accidental death insurance, vision insurance etc. [156]

The individual health insurance market functions as any other commercial industry, i.e. produces products for which there is a demand and dumps products that people do not buy to generate profit. On one side, competition holds down the prices and provides incentive to offer new products. On the other side, the main goal of private insurance companies is to generate profit, therefore they offer or deny offer of health care coverage as they wish (provided no state or federal rules prohibit these practices). Insurers marketing the individual health plans use different approaches for evaluation of potential clients than the group-sponsored plans do. One such evaluation technique is called medical underwriting, under which the insurance company identifies the applicant according to his/her health status. Some applicants who are likely to cost more than an average healthy person are then charged with enormous health premiums or even denied insurance. As a result, there are about 5 million people who are uninsurable due to their pre-existing medical conditions and thus remain uninsured unless they find another way how to obtain a health insurance. State laws have been limiting these practices for quite some time, but the 2010 health care reform will put a full stop to these practices on federal level once in effect.

4. 6. 2 State Risk-Pools

Two thirds of states have created high-risk pools as the insurance of last resort for those who were denied coverage or offered only very limited coverage policies on the private market due to their medical conditions if, at the same time, they are not eligible for public coverage. Risk-pools operate as a state-created non-profit association run by a board of directors made up of industry, consumer and state insurance department representatives. The board contracts with a private insurance company to collect the premiums and reimburse claims. The premiums for risk-pool coverage are higher than individual health plans (but are capped at some level, e.g. 200 % of premium for similar individual health plan on the market) and sometimes there is a

[156] Mark Farrah Associates. America´s Health Insurance Plans [online]. 28 July 2008 [cit. 2010-08-08]. Individual Health Insurance: An Overview of Products. Available at: <http://www.ahiphiwire.org/LearningCenter/Feature.aspx?doc_id=188552>.

waiting period before one may enroll. Risk-pools in no way help uninsured who lack insurance because of inability to pay for it. Although states may subsidize risk-pool insurance premiums sometimes for certain people, the clients still need to pay the premiums. State risk-pools need to be subsidized themselves since their costs are higher than revenues. Typically, some portion of state tax revenues finances risk-pools. Due to funding problems of risk-pools, waiting lists for applicants exist and currently there are only about 200,000 people in total insured by state risk-pools. [157]

4. 6. 3 Individual Health Insurance Regulation

Individual health insurance is primarily under state laws. States regulate individual insurance differently than group health insurance policies, although every state has adopted certain basic standards that apply to all health insurance products.

Typically, State´s Department of Insurance supervises the whole insurance market. The focus is mostly on consumer´s protection in both group and individual health insurance health plans; therefore these standards make sure that insurers are financially stable and solvent, pay claims promptly and so on. Every health insurance provider must obtain a license in the licensing process, where states review the finances (minimum capital requirements, assets, and reserve for payments of claims) and business policies to make sure the entity can keep their promises to future clients. Also brokers and agents selling insurance products need special license. States also procure guaranty funds (i.e. non-profit organizations founded to reimburse the clients of the insurance companies that become insolvent where all insurance companies pay contributions to). Insurance company must comply with market conduct requirements as well (advertising of products, claim policies) and withstand possible on-site examinations and controls. Even the model policy forms used to create a contractual relationship between an insurer and a client are subject to the state´s review or approval.

Other aspects of regulation mostly vary by state and by type of coverage. States have similar patient protection provisions, but for example review standards of insurance companies, access to health insurance or required benefits differ among states. States mostly seek to regulate access to health insurance (when and on what

[157] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

terms an insurer must accept an applicant for coverage) through "guaranteed issue" or "guaranteed renewability". While almost all employer-based health coverage plans must work on guaranteed issue basis, only a few states extend this obligation to individual health insurance providers. That is why the level of consumer protection fluctuates between states. Guaranteed renewability, on the other hand, is a federal requirement of HIPAA and thus all private health insurance plans, group or individual, must be renewable. Insurers logically react by increasing premiums. However, insurers are not allowed to increase premiums right after a policy holder gets sick (as a form of punishment for getting sick). Other state rules regulating access to insurance include for example obligatory coverage of a newborn for at least 30 days under parent´s health insurance.

States also regulate the methods by which insurers calculate premiums. There are two major approaches on the private health insurance market: (1) adjusted community rating and (2) medical underwriting. Adjusted community rating requires all policy holders to pay similar premiums, and unlike in community rating, some variations are allowed (usually only by gender and certainly not by medical condition). On the contrary, medical underwriting allows the private insurer to calculate the premiums based on evaluation of health status of an applicant from medical records. Based on the outcome, an applicant is then underwritten as either standard-risk (average health) or rate-up (existing medical condition). Rate-ups might be offered only the policy with "elimination rider" that basically excludes health coverage for that pre-existing condition under the plan. Applicants with serious health conditions may get denied completely. Only limited anti-discrimination laws apply on the private insurance market and the companies providing individual health insurance plans profit the most from the lack of regulation. Thus, while on the public coverage market, community rating prevails, on the individual health coverage market insurers adjust premiums according to gender, age, lifestyle activities (wellness participation, obesity), geographical locations, type of career etc. However, some states have already enacted laws prohibiting insurers from charging higher premiums based on health status. The 2010 health care reform will restrict the insurers in their rating policies as well.

Although the "rating laws" are aimed at protection of consumer, from the economic point of view they completely reverse the rules on which the insurance

market operates. Non-health insurance companies (e.g. life insurance, accidental insurance) naturally rate the insurance prices according to risks associated with individual policy holders under the common rules of risk management, but health insurance companies are prohibited from doing so by states´ belief that the price of health insurance premium should reflect the value of the benefits and not the risks of the people who purchase the benefits. [158] Thus, market distortions occur and the government needs to take (and finance) actions to correct them, further stretching the health care bill.

[158] STOLTZFUS JOST, Timothy. The Regulation of Private Health Insurance [online]. [s.l.] : National Academy of Social Insurance, January 2009 [cit. 2010-08-05]. Available at:
< http://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf>.

5. PUBLIC HEALTH INSURANCE

Primarily, public health insurance programs (government programs) cover health care of seniors and low-income individuals, families and children. Military health benefits and health coverage for Native Americans also exist within the public health coverage system. Although most public health plans are established by federal government, some states run additional state public health insurance plans.

5. 1 Medicare

Medicare is the U.S. federal public health-social insurance programs for people aged 65 or over, people under 65 with certain disabilities and individuals with permanent kidney failure. [159] Apart from health insurance provision, Medicare finances for example residency training of majority of the U.S. physicians by covering residents´ salaries. [160] In 2010, approximately 46.5 million people are enrolled in Medicare, out of which 39 million people are elderly.

5. 1. 1 Development of Medicare

Congress designed Medicare to improve general welfare in the U.S. The federal nature of Medicare is based on the taxing and spending powers of the federal government, along with the commerce clause of the Constitution. Prior to establishment of Medicare and Medicaid, health insurance operated as an employment benefit. However, two groups were left out of health insurance: the retired elderly and the poor unemployed. President Harry S. Truman first proposed medical coverage program for the elderly in the 1940s, but his efforts were never enacted. In 1960, the Kerr-Mills Act tried to provide federal support for state medical programs serving poor retirees. But

[159] Social Security Administration. Medicare [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-06]. Available at: <http://www.ssa.gov/pubs/10043.pdf>.

[160] Residency (medicine)#Financing residency programs. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 9 November 2004, last modified on 31 July 2010 [cit. 2010-08-12]. Available at: <http://en.wikipedia.org/wiki/Residency_(medicine)#Financing_residency_programs>.

only a few states participated and due to inconvenient grant matching formula, the poorest states received the smallest portion of federal money. [161] Finally, in 1964, President Lyndon Johnson initiated the adoption of Medicare and Medicaid under the Social Security Act of 1965. Medicare program gathered a lot of support, but there were also some opponents, for example the AMA, which saw the federal intervention on the health insurance and health care market as "socialized medicine". To please the opponents, Medicare was made voluntary for the medical providers to participate in and awarded them with generous pay for their health services for Medicare as an incentive. Now, Medicare is less voluntary, payment rates are lower and the federal government basically supervises the delivery of health care services. [162]

Several laws were repealed since the establishment of Medicare. Applicable Medicare laws now include, apart from the initial Social Security Act, the Balanced Budget Act of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act, also known as the Medicare Modernization Act of 2003 (MMA). The MMA is the largest Medicare expansion since 1965 and establishes, among other things, a prescription drug coverage benefit. The health care reform legislation of 2010 further expands prescription drugs coverage and prevention benefits and its provisions slow down the growth of Medicare payments to health care providers.

5. 1. 2 Operation of Medicare [163]

The Centers for Medicare and Medicaid Services - components of the HHS, and Social Security Administration administer Medicare. The program is funded through a mix of payroll taxes, premiums and general tax revenues.

Medicare does not provide health care directly do its members. Instead, it helps with medical expenses; however it does not pay for all the costs of health care services provided to its members. The vast majority of physicians, hospitals and related medical providers participate in Medicare. If a Medicare member receives a Medicare covered service or a product (such as a physician´s visit), Medicare will pay. Alongside

[161] Answers.com : West´s Encyclopedia of American Law [online].Thomson Gale, Inc., 1998 [cit. 2010-08-05]. Medicare. Available at: <http://www.answers.com/topic/medicare>.

[162] OUTTERSON, Kevin. Enotes.com : Major Acts of Congress [online].Thomson Gale, Inc., 2004 [cit. 2010-08-06]. Medicare Act (1965). Available at: <http://www.enotes.com/major-acts-congress/>.

[163] The Kaiser Family Foundation. Medicare : A primer 2010 [online]. [s.l.] : [s.n.], April 2010 [cit. 2010-08-12]. Available at: <http://www.kff.org/medicare/upload/7615-03.pdf>.

Medicare, various supplementary private insurance policies are offered to Medicare members to cover the services that Medicare does not include or reimburses only partially. These policies are known as Medigap. Medicare health insurance consists of four parts: A, B, C and D. [164]

Part A, "hospital insurance", helps pay for inpatient care in a hospital or in a skilled nursing facility, some forms of home health care and hospice care. Enrollees do not usually pay premiums for this coverage, because they paid Medicare taxes[165] during their employment years. However, they are subject to deductibles ($ 1,100 in 2010) and co-payments/co-insurances as in private health insurance programs.

Part B, "medical insurance", helps pay for physicians´ services, outpatient hospital care, some home health care and other medical services (e.g. diagnostic services) and supplies not covered by Part A Medicare. Anyone enrolled in Part A may participate in Part B for a monthly premium of approximately $ 110.0 (in 2010). Deductibles and co-payments/co-insurances also apply.

Parts C, "Medicare Advantage Plans", was established in 1997 by the Balanced Budget Act as "Medicare Plus Choices" and later reviewed and renamed in the Medicare Modernization Act of 2003 to "Medicare Advantage". It is a health coverage option run by private insurance companies approved by and under contract with Medicare. Medicare members can choose whether to receive Medicare benefits through Medicare Parts A and B plans, or through private health insurance plans (that cover prescription drugs as well unlike Medicare Parts A and B). Medicare Advantage Plans are usually in the form of HMO or PPO. Medicare pays for Medicare Advantage private health insurance [166]. In 2010, about 11 million people were enrolled in Medicare Part C.

Part D, "Prescription Drug Coverage", helps pay for prescription drugs and treatments. [167] This is a private insurance run by Medicare-approved insurance

[164] OUTTERSON, Kevin. Enotes.com : Major Acts of Congress [online].Thomson Gale, Inc., 2004 [cit. 2010-08-06]. Medicare Act (1965). Available at: <http://www.enotes.com/major-acts-congress/>.

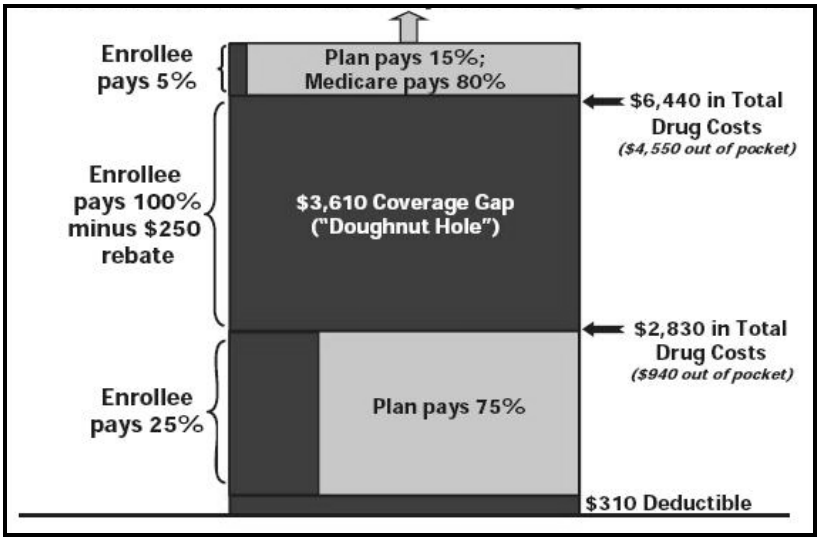
[165] 2.9 % tax on earnings paid by employers and employees (1.45 % each)

[166] The Kaiser Family Foundation. Medicare Advantage [online]. [s.l.] : [s.n.], November 2009 [cit. 2010-08-07]. Available at: <http://www.kff.org/medicare/upload/2052-13.pdf>.

[167] Social Security Administration. Medicare [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-06]. Available at: <http://www.ssa.gov/pubs/10043.pdf>.

companies, which are under contract with Medicare. [168]Medicare members pay a monthly contribution of approximately $ 39.0 on average [169] (in 2010) along with part of costs for each prescription. In exchange, they may choose a drug plan that best fits their needs. Medicare beneficiaries should enroll once they become eligible, because later joining might be subject to penalties, according to particular private insurance companies´ insurance terms. [170] Medicare Part D was created by the MMA and has been in effect since 2006. Eligible beneficiaries are those who are enrolled in Medicare Part A and/or B and those eligible for both Medicaid and Medicare. Medicare Part D exists in two versions: (1) Medicare Prescription Drug Plan (PDP) offering separate drug coverage only plan, or (2) as a part of Medicare Advantage Plan covering both prescription drugs and medical services together (i.e. Medicare Part C). Two thirds of Medicare Part D beneficiaries (out of total nearly 28 million Part D beneficiaries) are enrolled in PDPs. Medicare prescription drug plans are required to offer at minimum either standard benefit package as defined in law or an alternative "equal in value". Some plans provide even more enhanced benefits. However, a coverage gap exists. The following figure explains how Medicare prescription drug financing works (in 2010):

Figure 5.1.2.1: Standard Medicare Prescription Drug Benefit Payment Distribution



[168] Centers for Medicare and Medicaid Services. Medicare and You : The official government handbook [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-07]. Available at: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

[169] the premiums for PDPs vary greatly among states, ranging from $ 8.80 in Oregon to $ 120.20 in Washington, DC in 2010

[170] U.S. Department of Health and Human Services : Centers for Medicare and Medicaid Services [online]. 2005 [cit. 2010-08-07]. Medicare. Available at: <http://www.cms.gov/MedicareGenInfo/>.

Source: The Kaiser Family Foundation. Medicare : A primer 2010 [online]. [s.l.] : [s.n.], April 2010 [cit. 2010-08-12]. Available at: <http://www.kff.org/medicare/upload/7615-03.pdf>.

The standard prescription drug benefit plan has an annual $ 310.0 deductible, meaning that Medicare does not pay anything unless this deductible is met or exceeded. After a deductible is reached, Medicare enrollees pay 25 % co-insurance of up to $ 2,830 of total drug costs, corresponding to $ 940 out-of-pocket. Then, so called "doughnut hole" coverage gap follows. Within the coverage gap, enrollees are required to pay all their drug costs out-of-pocket until they have spent additional $ 4,550 for the drugs from their own funds. After exceeding $ 4,550, 5 % co-insurance or co-payments from $ 2.50 (generics)[171] [172] to $ 6.30 (brand name drugs) per prescription apply for the rest of the year. The 2010 health care reform provides $ 250.0 rebate per each spending within the coverage gap, effective from 2010.

Nevertheless, only 11 % of PDPs offer standard benefit plan as described above. Most charge co-payments instead of initial 25 % co-insurance and only 36 % of PDPs set a full deductible of $ 310.0. 80 % of PDPs do not reimburse the coverage gap, but 20 % offer at least some contribution within the doughnut hole for generic drugs. Although prescription drug coverage in general is not cheap, 90 % of all Medicare enrollees have some form of coverage for prescription drugs. Apart from Medicare Part D coverage (27.7 million people enrolled), enrollees benefit from employer retiree benefits coverage (8.3 million) or purchase separate prescription drug coverage on the market (5.9 million).

Many of the services now covered by Medicare were not part of the "original Medicare package". Over time, Congress has been adding further and further benefits. This process is called "incrementalism". While it is advantageous for the members to have additional coverage, expanding list of coverage results in higher costs of Medicare.

[171] A generic drug is a drug manufactured without patent protection after the exclusive patent rights of the respective brand drug have expired. It is usually interchangeable with the brand drug with regard to the main effective ingredient and cheaper when compared with the brand name drug due to lack of patent protection rights.

[172] World Health Organization [online]. 2010 [cit. 2010-08-12]. Generic Drugs. Available at: <http://www.who.int/trade/glossary/story034/en/index.html>.

Medicare cost $ 7.7 billion in 1970. In 2000, it was already $ 224 billion per year. [173] In 2009, the Medicare expenses totaled to $ 484 billion. [174]

Still, Medicare has significant gaps in coverage of certain services. Most notably, Medicare does not pay for nursing homes or assisted living care, dental checkups, vision care or eyeglasses or hearing aids. Moreover, Medicare has high deductibles and cost-sharing provisions and no limits for out-of-pocket spending exist. Thus, most Medicare enrollees need to purchase supplementary coverage for a separate premium to limit their out-of-pocket costs.

Even Medicare sometimes faces litigations. Most of the time courts resolve administrative issues whether a particular service is covered or not. Medicare itself files suits for "Medicare frauds", where a certain Medicare provider is alleged of breaking the Medicare complex rules. However, Medicare rules are so complicated that most "frauds" show to be innocent unintentional mistakes. The most significant litigation for patients concerns the process that the government must follow when denying benefits. [175] Medicare seriously encourages patients to report billing and other frauds under federal fraud and abuse laws. A patient who reports suspected Medicare fraud, which is not already being investigated, may receive up to $ 1,000 should the report lead directly to the recovery of at least $ 100 of Medicare money. Medicare also employs the Medicare Beneficiary Ombudsman to review and resolve any Medicare related issues. [176]

[173] Social Security Administration. Medicare [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-06]. Available at: <http://www.ssa.gov/pubs/10043.pdf>.

[174] The Kaiser Family Foundation. Medicare spending and financing [online]. [s.l.] : [s.n.], May 2009 [cit. 2010-08-07]. Available at: < http://www.kff.org/medicare/upload/7305-04-2.pdf >.

[175] Social Security Administration. Medicare [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-06]. Available at: <http://www.ssa.gov/pubs/10043.pdf>.

[176] Centers for Medicare and Medicaid Services. Medicare and You : The official government handbook [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-07]. Available at: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

5. 2 Medicaid [177]

Medicaid is a means tested U.S. public health care program primarily for low-income individuals and their families without lack of access to private health insurance who fit into an eligibility group that is recognized by federal and state law. Also, people with chronic illnesses, disabilities and low-income seniors are covered by Medicaid. Private health insurance system is designed to fit the needs of generally healthy population and people with health conditions are often denied health coverage. Still, most health insurance plans, even public, do not cover long-term health care necessary for chronically ill people or seniors. Thus, without public help, these people would be left uninsured.

Medicaid is jointly funded by both federal and state governments. States manage and administer the operation of the program and set their own guidelines regarding eligibility and covered services. [178] Over time, Medicaid has been significantly expanded to fill more coverage gaps left by the private health insurance system. During current economic recession, Medicaid provides safety net of health coverage for people left uninsured due to sudden loss of employment or decline in income and covers more people than any other public health insurance program, including Medicare. Health care reform laws further expand Medicaid scope. Currently, Medicaid covers nearly 68 million people, out of which over 8 million are low-income Medicare beneficiaries who rely on Medicaid assisting with high Medicare out-of-pocket payments.

5. 2. 1 Development of Medicaid

Medicaid was established as an amendment to the Social Security Act of 1935 in 1965 (known as the Social Security Act of 1965 after amendments). Prior to 1965, opposition of the medical profession and private insurers prevented adoption of publicly funded health insurance for the poor. At that time, various programs finances by state and local governments, charities and community hospitals provided limited health coverage for the indigent. In 1960, the Kerr-Mills Act provided federal support for state medical programs for the aged poor. However, as mentioned above, only a few states

[177] The Kaiser Family Foundation. Medicaid : A primer 2010 [online]. [s.l.] : [s.n.], June 2010 [cit. 2010-08-12]. Available at: < http://www.kff.org/medicaid/upload/7334-04.pdf>.

[178] U.S. Department of Health and Human Services : Centers for Medicare and Medicaid Services [online]. 2010 [cit. 2010-08-07]. Medicaid. Available at: <http://www.cms.gov/MedicaidGenInfo/>.

showed interest in the program. By 1965, there was a consensus for establishing more comprehensive public health insurance program. Thus, when the Medicare legislation was being prepared, Senator Wilbur Mills added another section to the amended Social Security Act and Medicaid was born as a program for poor of all ages. As a result, persons who met federal financial eligibility requirements were entitled to health care. Medicaid was designed to help not only the poor already eligible for public assistance, but also to those whose incomes fell just above the level of "medical poorness". Like Medicare, Medicaid pays the fees to medical providers that take care of eligible poor. Medicaid has over time developed into the national social welfare system. One major weakness of Medicaid is the diversity of quality and covered services among individual states. Due to rising costs of health care since the 1970s, state and federal government both have made restricting efforts to regulate medical providers´ fees and limit eligibility and range of covered services. [179] In 1990, the Omnibus Reconciliation Act of 1990 created the Medicaid Drug Rebate Program by adding Section 1927 to the Social Security Act. In 1992, the program was amended by the Veterans Health Care Act. The Omnibus Reconciliation Act of 1993 then amended the program once more and adopted further changes to the Medicaid Drug Rebate Program [180] The Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the HHS and other agreements with the Department of Veteran Affairs for states to receive federal funding for outpatient drugs dispensed to Medicaid patients. Approximately 550 pharmaceutical companies participate in the program and all states but Arizona cover drugs under the Medicaid Drug Rebate Program. [181] Since the adoption of the MMA in 2003, beneficiaries who are eligible for both Medicare and Medicaid have qualified for Medicare Part D prescription drug coverage. [182]

[179] Answers.com : Encyclopedia of Public Health [online].The Gale Group Inc., 2002 [cit. 2010-08-07]. Medicaid. Available at: <http://www.answers.com/topic/medicaid>.

[180] Medicaid. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 9 June 2002, last modified on 1 August 2010 [cit. 2010-08-12]. Available at: <http://en.wikipedia.org/wiki/Medicaid>.

[181] U.S. Department of Health and Human Services : Centers for Medicare and Medicaid Services [online]. April 2010 [cit. 2010-08-07]. Medicaid Drug Rebate Program. Available at: <http://www.cms.gov/MedicaidDrugRebateProgram/>.

[182] The Kaiser Family Foundation. Medicare : A primer 2010 [online]. [s.l.] : [s.n.], April 2010 [cit. 2010-08-12]. Available at: <http://www.kff.org/medicare/upload/7615-03.pdf>.

5. 2. 2 Operation of Medicaid

Medicaid functions on the grounds of joint endeavor of federal government and state governments. Federal government provides monetary contributions to the states, i.e. "matches" state spending. No cap (maximum limit) on federal contribution is set. States receive federal funds based on actual needs and current matching arrangements. Federal government reimburses states for their spending on Medicaid, reimbursements ranging from 50 % to 85 %. Average reimbursement is 59 %, meaning that the federal government pays 59 cents for every dollar spent on Medicaid by states. The American Recovery and Reinvestment Act of 2009 (ARRA) allowed temporary increase in federal matching rates to enable states finance the boost in Medicaid enrollment due to current economic situation. Thanks to ARRA, the maximum federal match rate (also known as the FMAP: Federal Matching Assistance Rate) has grown from 76 % to 85 % since 2008. The enhanced matching rates will expire at the end of 2010 unless extended by Congress.

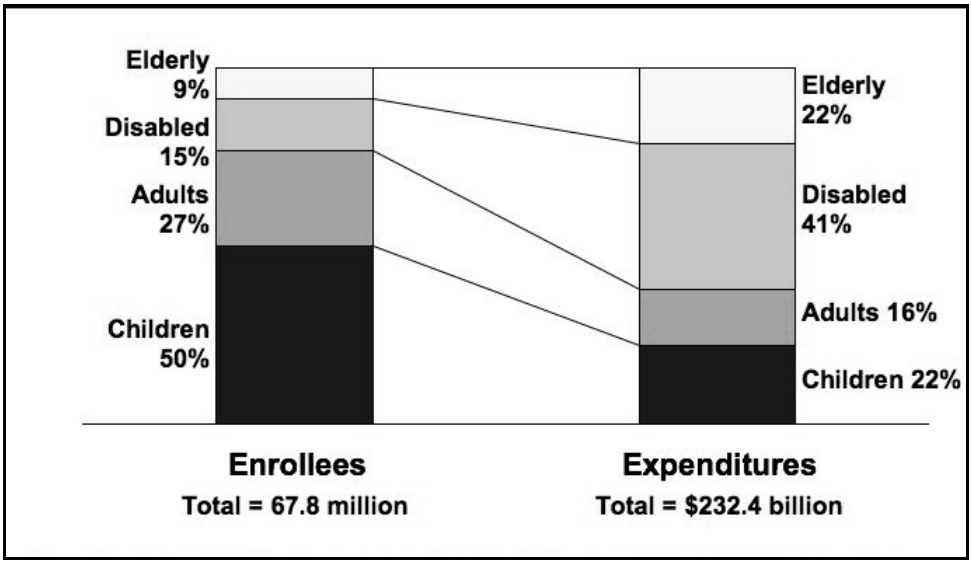
States administer the program based on federal guidelines, thus there are many differences in Medicaid programs among states. Federal law outlines minimum requirements, but states have the authority to define eligibility requirements, benefits, provider payments or delivery systems. States are sometimes allowed to waive out of federal statutes and guidelines. These exceptions are granted by the Secretary of the HHS under the Social Security Act. Usually, states use waivers to expand eligibility.

Medicaid is major social welfare program. [183] There were 58.1 million of people enrolled in 2007.[184] As the financial crisis and unemployment level progressed, people turned to Medicaid as their only source of health care coverage; consequently, in 2009, there were 67.8 million people enrolled in Medicaid. It is estimated that for every one percentage point increase in the unemployment rate, the Medicaid enrollment grows by 1 million. The following figure shows the distribution of enrollees in 2009.

[183] Answers.com : Encyclopedia of Public Health [online].The Gale Group Inc., 2002 [cit. 2010-08-07]. Medicaid. Available at: <http://www.answers.com/topic/medicaid>.

[184] The Kaisser Family Foundation : statehealthfacts.org [online]. 2010 [cit. 2010-08-07]. Total Medicaid Enrollment FY 2007. Available at: <http://www.statehealthfactsonline.org/comparemaptable.jsp?cat=4&ind=198>.

Figure 5. 2. 2. 1: Medicaid Enrollees and Expenditures by Enrollment Group, 2009



Source: Georgetown University Health Policy Institute : Center for Children and Families [online]. 2008-2009 [cit. 2010-08-12]. About Medicaid for Children and Families. Available at: <http://ccf.georgetown.edu/index/about-medicaid-full>.

Medicaid eligibility is based on several factors. Overall, it focuses on low-income and high-need population. Eligible people are those on welfare and "medically needy" people (their incomes exceed the limits for welfare, but they are too low to pay for health coverage). Since 1988, Medicaid has been providing health coverage to "working poor" (low-income employees with no health coverage). Under current legislation, coverage depends on both the income (financial criteria) and the fact whether a person belongs to one of eligibility groups. Primarily eligible are low-income children, pregnant women, elderly people, people with disabilities and blind people, and parents not exceeding specific income thresholds. Single adults are not eligible, no matter how poor, unless they are disabled or pregnant. Elderly people are sometimes "dual eligibles", receiving Medicare health coverage along with Medicaid. Medicaid then pays for co-payments and other costs arising out of not-Medicare-covered services. States can set their own criteria for income and asset to qualify for Medicaid. However, states are prohibited under federal law from reducing other welfare benefits for people who become eligible for Medicaid. States also cannot impose other residency requirements than that a Medicaid applicant is a citizen of the state. No age limits apply for Medicaid eligibility. The 2010 health care reform simplifies and unifies the eligibility criteria, enacting that almost all people under 65 with incomes below certain

national "floor" will be eligible, regardless the need to fit into one of the eligibility groups.

Federal government uses mandates to regulate Medicaid services towards better consistency among the states. Every patient is thus entitled to a federally guaranteed minimum package of health care services including inpatient and outpatient hospital care; physician, midwife, and certified nurse practitioner services; laboratory and X-ray services; nursing home care and home health care; early and periodic screening, diagnosis, and treatment for children under twenty-one years of age; family planning; rural health clinic/federally qualified health center services; and transportation services. These services are available for treatments of conditions that cause "acute suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity or present a significant handicap. States can provide other optional services. All states provide vision care and prescription drugs; some states have added coverage for physical therapy, hospice care, rehabilitative services, hearing aids, intermediary facilities for mentally retarded etc. Dental services are also included in Medicaid. Minimum services include pain relief, restoration of teeth and dental health maintenances. Medicaid is the only significant public program providing financing for long-term care (nursing homes). 70 % of residents in nursing homes are covered by Medicaid. Also, Medicaid finances treatment for about half of all AIDS patients in the U.S. [185] and pays for 40 % of all childbirths. Medicaid significantly supports health costs of pre-term babies and people with Alzheimer´s disease and is the largest payer of health care for people with mental diseases. States are required by laws to provide the same benefit package to all categorically eligible individuals. However, in 2005, the Deficit Reduction Act enabled states to provide more limited benefits ("benchmark" benefits) to some groups of beneficiaries, although most people are exempt from the benchmark benefits. States use this authority to for example differentiate health care benefits based on individual health behaviors (e.g. people who do not show up for preventive check-ups may receive more limited health care coverage than people who do).

In 2008, federal government passed a rule to enable states to charge higher premiums and co-payments for Medicaid. Higher co-payments allow states to struggle

[185] HIV must progress near to AIDS to be covered by Medicaid

less with financing Medicaid and educating patients to become more efficient health care consumers. Critics claimed that people with the lowest incomes would forgo the necessary health care due to co-payments. As a result, limits for premiums and co-payments were set. The total of all charges cannot exceed 5 % of the family´s income and most children and other beneficiaries with incomes up to 150% of the national poverty level are exempt from any cost-sharing or their cost-sharing is very limited. For example, recipients at or below that poverty level ($ 33,075 a year for a family of four in 2009/2010[186]) can be charged only up to $ 3.40 a doctor´s visit/a service. Recipients above the poverty level generally pay co-insurances up to 20 % of the actual costs. Thus, a $ 150.0 drug will cost as much as $ 30.0 for these recipients. [187] Some states cap the amount of certain services Medicaid reimburses, for example by imposing limits on the number of covered physician visits a year.

Although Medicaid is publicly financed, it purchases medical services from private sector (unlike for example Military Health System which both pays for and delivers health care services). Medicaid services used to be delivered on a fee-for-service basis, but now most states use managed care plans to cut down the costs. Since the Medicaid enrollees were often refusing managed care plans, the Balanced Budget Act of 1997 had to enact that states might require that Medicaid applicants enroll in managed care. Now, most of the states direct Medicaid members to network providers of some kind of managed care organization. A few states established Health Insurance Premium Payment Program (HIPP), giving the Medicaid recipients possibility to find a private health insurance program that Medicaid will pay for. The interest in HIPP is slowly rising among the recipients.

Medicaid payment is made directly to the medical providers, which need to be approved by Medicaid. Due to rising health care costs, health care providers are not fully reimbursed for the services they provide. Budget cuts resulted in so low reimbursements (e.g. $ 25 per visit in Michigan in 2008) that physicians were losing money every time a Medicaid patient came to their office and thus could not afford to

[186] U.S. Department of Health and Human Services : Administration for Children and Families [online]. 2010 [cit. 2010-08-19]. 2009/2010 HHS Poverty Guidelines. Available at: <http://liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm>.

[187] PEAR, Robert . New Medicaid Rules Allow States to Set Premiums and Higher Co-Payments . The New York Times [online]. 26 November 2008 [cit. 2010-08-08]. Available at: <http://www.nytimes.com/2008/11/27/us/27medicaid.html?_r=3&scp=2&sq=medicaid&st=cse>.

pay for the staff, malpractice insurance or laboratory services. Consequently, some physicians have limited the number of Medicaid patients or even refused to see Medicaid patients at all. On average, Medicaid reimbursements reach only 72 % of Medicare reimbursements, while Medicare coverage is already well below commercial insurance rates. [188] Gaps in access to health care services, especially specialist and dental, are major concern for Medicaid. New health reform legislation provides more funds to help deal with this issue.

Medicaid struggles with several other problems, mostly because of its size and complexity. Medical fraud and abuse proliferates [189], people divest their assets and resources to qualify for Medicare (e.g. elderly donate assets to their children to receive free Medicaid nursing home care) etc. As a result, health care for truly needy is limited in order to save some finances. Should an individual sell or give away asset or resource for less than fair market price, the Social Security Administration must inform the Medicaid Agency. Penalties for mischievous practices include ineligibility for Medicaid for a certain period of time. The number of the fraudulent transfers led Congress in 1996 to make such persons subject to criminal liability for "*knowing and willful disposal of assets in order…to become eligible for medical assistance*".

Medicaid imposes stringent limits on assets and incomes of Medicare recipients. Many people, in order to qualify for free long-term nursing care, would have to pay thousands of dollars out-of-pocket every month for nursing care before the amount of their assets let them qualify for Medicaid. So instead, they seek help on the market with asset management programs to protect their assets while being eligible for Medicaid care. As a result, since the beginning of Medicaid, states have been permitted to recover Medicaid payments from the estate of certain deceased Medicaid members with no living spouse or child. States were allowed to impose liens on the property of the deceased Medicaid member to prevent the distribution of estate to heirs. But recovery of estate was not obligatory until the Omnibus Budget Reconciliation Act of 1993. The Omnibus Budget Reconciliation Act of 1993 mandated states to implement federal Medicaid Estate Recovery Program, requiring that states seek adjustment or recovery of amounts correctly paid by the state for certain people with Medicaid. States must, at a

[188] SACK, Kevin. As Medicaid Payments Shrink, Patients Are Abandoned. The New York Times [online]. 15 March 2010, 0, [cit. 2010-08-10]. Available at: <http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html>.

[189] 10 % of Medicaid expenditures are presumed to have paid for fraudulent claims by medical providers

minimum, seek recovery for services provided to any person of any age in a nursing facility, intermediate care facility for mentally retarded or other mental institution. For individuals over 55 years of age, states must seek recovery of payments from the individual´s estate for nursing care facility services, home and community based services and related hospital and prescription drug services. States have the option, but not the obligation, to recover any other Medicaid payments. States recover at a minimum from assets passing through probate, and at a maximum from all assets of deceased Medicaid recipient. Should the recovery cause an "undue hardship", states may waive the estate recovery. States also cannot recover from a surviving spouse or child under 21 years, or from a blind or disabled child. [190] [191]

Medicaid has been the main project for the most vulnerable and needy Americans. However, not all indigent people qualify for Medicaid. That is why most states administer additional medical assistance programs for poor people who are not eligible for Medicaid. However, no federal contribution helps fund these projects. [192] Generally, Medicaid leaves out: most parents of poor children (income eligibility requirements for children are much less strict in most states than income eligibility requirements for their parents); adults without dependent children unless they are disabled or pregnant or immigrants for the first five years of their stay in the U.S. The 2010 health care has taken measures to set right some of the key Medicaid problems.

Several states renamed Medicaid. Thus, California´s Medicaid is "Medi-Cal", Tennessee´ s "TennCare" or Massachusetts´ s "MassHealth". [193]

[190] U.S. Department of Health and Human Services. Medicaid Estate Recovery [online]. [s.l.] : [s.n.], April 2005 [cit. 2010-08-10]. Available at: <http://aspe.hhs.gov/daltcp/reports/estaterec.pdf>.

[191] U.S. Department of Health and Human Services : Centers for Medicare and Medicaid Services [online]. 2005 [cit. 2010-08-09]. Estate Recovery. Available at: <http://www.cms.gov/MedicaidEligibility/08_Estate_Recovery.asp>.

[192] U.S. Department of Health and Human Services : Centers for Medicare and Medicaid Services [online]. 2010 [cit. 2010-08-07]. Medicaid. Available at: <http://www.cms.gov/MedicaidGenInfo/>.

[193] Medicaid. In Wikipedia : the free encyclopedia [online]. St. Petersburg (Florida) : Wikipedia Foundation, 9 June 2002, last modified on 1 August 2010 [cit. 2010-08-12]. Available at: <http://en.wikipedia.org/wiki/Medicaid>.

5. 3 Children´s Health Insurance Program (CHIP)

5. 3. 1 Development of CHIP

State Children´s Health Insurance Program was created in 1997 by the Balanced Budget Act of 1997 to provide affordable health coverage to low-income children in working families with modest incomes, but too high to qualify for Medicaid and too low to pay for private health insurance. Now it is referred to only as the Children´s Health Insurance Program or CHIP. It operates on a state-federal partnership.

CHIP was originally authorized for 10 years (1997 - 2007). In order for it to continue, federal action had to be taken before the end of September 2007. Congress passed legislation to continue the program two times in 2007, but it was always vetoed by President Bush. In response, Congress passed so called "stopgap" legislation (the Medicare, Medicaid, and CHIP Extension Act of 2007) to extend the program through 2009. Later, in January 2009 Congress passed the Children´s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In February 2009, President Barrack Obama signed the CHIPRA into law, thus formally reauthorizing the program through 2013 and expanding its scope. Further, President Obama sent a memorandum to states to immediately withdraw the "August 17, 2007 Directive" imposing conditions on states and limiting their option to provide health insurance for uninsured children and requested implementing the CHIP regardless these requirements. The program currently provides health coverage for more than 7 million children and aims to enroll 4 more million of uninsured children by 2013.

5. 3. 2 Operation of CHIP

States have flexibility to establish income eligibility rules for CHIP, but their flexibility is limited by federal guidelines. Within federal guidelines, each state designs its own program, including eligibility, benefits, payment levels for coverage and administrative procedures. Centers for Medicare and Medicaid produce guidelines. States may design the program as a part of Medicaid (by extending Medicaid) or as a separate program, or as a combination thereof. The CHIP benefit package must always cover routine check-ups, immunizations, dental, inpatient and outpatient hospital care and laboratory and x-ray services. Since CHIPRA, dental care is obligatory, not voluntary benefit offered by states. States must offer dental health plan that is

equivalent either to the children´s coverage under the FEHBP program, or to state employee dependent dental coverage, or to the commercial dental health plan in the state with the highest-non Medicaid enrollment. Also, any children with private health plan not including dental health coverage must be offered the CHIP dental coverage provided they are otherwise eligible for CHIP (i.e. the only requirement not fulfilled is that "the child is uninsured"). This provision was adopted due to the fact that most private health care plans do not cover dental care and many children lack dental care even if they are otherwise insured. The Mental Health Parity Act also applies. Preventive care must be free. Other services may be provided for some cost-sharing.

Every U.S. state offers CHIP, most states use unique names for the program, such as "HealthyFamily" in California, "PeachCare" in Georgia, "KidCare CHIP" in Wyoming or "New York Child Health Plus" in New York. [194] In early 2010, Arizona decided to cancel the CHIP as of 15 June 2010 due to state budget deficit. Arizona would have been the only state without children´s federal health insurance if the cancellation had gone through. However, as Arizona faced the threat that $ 7 billion of federal funds would have been cut as a consequence, the program was restored, but froze the enrollment until 2014. The Arizona´s plan is that when federal 2010 health care reform provisions kick in and expand the scope of Medicaid eligibility in 2014, the remaining CHIP recipients will transfer to Medicaid and the CHIP program will then be canceled. [195] [196]

The overall goal of CHIPRA is to further increase the ability of states to enroll more children through increasing amount of money available to states and through significant changes of money flow within the CHIP program. States receive an enhanced federal contribution. On average, for every 1 dollar states spend on CHIP, federal government contributes $ 2.57 to provide for health coverage. The law also allows states to provide coverage to legal immigrant children and pregnant women who

[194] InsureKidsNow.gov [online]. 2010 [cit. 2010-08-08]. What is CHIP. Available at: <http://www.insurekidsnow.gov/chip/index.html>.

[195] BEARD RAU, Alia. The Arizona Republic [online]. 20 March 2010 [cit. 2010-08-12]. Needy Arizona children to lose health care. Available at: <http://www.azcentral.com/arizonarepublic/news/articles/2010/03/20/20100320arizona-kids-lose-health-coverage.html>.

[196] ROUGH, Ginger. The Arizona Republic [online]. 15 May 2010 [cit. 2010-08-08]. KidsCare enrollment shrinking since signups frozen. Available at: <http://www.azcentral.com/arizonarepublic/local/articles/2010/05/15/20100515kidscare-enrollment-dropping.html>.

have been in the U.S. for less than 5 years and hence do not qualify for Medicaid. The CHIPRA contains provisions that reduce the possibility that states will expand coverage to children from families with incomes above 300 % of the poverty level (above $ 66,150 a year for a family of four in 2009/2010 [197]). [198] [199]

CHIP covers U.S. citizen children and legal immigrant children from "unborn" (through care for pregnant women) up to 18 years of age. In the past, pregnant women were mostly covered through Medicaid. Now, CHIP may extend the coverage to pregnant women who are above the income level for Medicaid. [200]

States only receive full federal contribution on children from families with income below 300 % of the poverty level. Children from wealthier families may still be covered, but federal contribution is equal to Medicaid contribution. New York and New Jersey have been exempted from this restriction. Most states however only cover children from families with incomes up to 200 % of poverty level ($ 44,100 a year for a family of four in 2009/2010 [201]). As of CHIPRA, legal immigrant children and pregnant women are covered through CHIP as well regardless how long they have been immigrants. [202] Before CHIPRA, some parents and adults were also covered under CHIP on the basis of a federal waiver from the legislation. No new waivers are being issued now and once the old waivers run out, adult recipients of CHIP benefits will be shifted out of the system.

The main goal of CHIP for the upcoming period until 2013 is to enroll more children. Congress intends to provide health coverage for another 4 million uninsured

[197] U.S. Department of Health and Human Services : Administration for Children and Families [online]. 2010 [cit. 2010-08-19]. 2009/2010 HHS Poverty Guidelines. Available at: <http://liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm>.

[198] NCSL : National Conference of State Legislatures [online]. 2010 [cit. 2010-08-08]. Children's Health Insurance Program (CHIP). Available at: <http://www.ncsl.org/default.aspx?tabid=14510>.

[199] SULLIVAN, Jennifer. CHIPRA 101 : Overview of the CHIP Reauthorization Legislation [online]. Washington, DC, USA : [s.n.], 2009 [cit. 2010-08-07]. Available at: <http://www.familiesusa.org/assets/pdfs/chipra/chipra-101-overview.pdf>.

[200] The Kaiser Family Foundation. NEW FEDERAL FUNDING AVAILABLE TO COVER IMMIGRANT CHILDREN AND PREGNANT WOMEN [online]. [s.l.] : [s.n.], July 2009 [cit. 2010-08-08]. Available at: <http://www.kff.org/medicaid/upload/7915.pdf>.

[201] U.S. Department of Health and Human Services : Administration for Children and Families [online]. 2010 [cit. 2010-08-19]. 2009/2010 HHS Poverty Guidelines. Available at: <http://liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm>.

[202] five-year waiting period applied before CHIPRA

children in addition to current 7 million enrollees. About one-third of the 4 million uninsured is eligible for Medicaid at the same time, the rest qualifies only for CHIP. States were presented with several options to reach out to these children, such as the "Express Lane Eligibility" or "Auto-Enrollment". Express Lane Eligibility allows CHIP and Medicaid agencies to accept income determinations from state agencies that provide for some other means-tested programs, such as free or reduced-price school lunch program, instead of requiring families to document their incomes again separately. Auto-Enrollment allows families who apply for other means-tested programs to give consent with auto-enrollment in CHIP or Medicaid if the child is proven eligible for CHIP during the eligibility process for other means-tested program. States also provide for interpretation and translation services to minorities during the eligibility process and health care delivery. [203]

5. 4 Military Health System (MHS) and TRICARE [204]

The Military Health System (MHS), administered by the U.S. Department of Defense, exists to: (1) maintain the health of the military personnel, so they can fulfill their military missions and (2) deliver health care during wartime. MHS also includes health care provided to dependents of active duty services members and of retired service members, known as TRICARE. TRICARE and MHS are sometimes jointly referred to as the Military Health Services System (MHSS).

MHSS is run by the Assistant Secretary of Defense for Health Affairs under the Secretary of Defense. Military medical facilities and personnel are managed by so called "Surgeons General" of the Army, Navy and Air Force.

All of the following are entitled to receive health care at military medical facilities:

- active duty personnel;
- active duty dependents, military retirees and their dependents and survivors of deceased members, provided space and professional services are available;

[203] SULLIVAN, Jennifer. CHIPRA 101 : Overview of the CHIP Reauthorization Legislation [online]. Washington, DC, USA : [s.n.], 2009 [cit. 2010-08-07]. Available at: <http://www.familiesusa.org/assets/pdfs/chipra/chipra-101-overview.pdf>.

[204] BEST, Richard A., Jr. Military Medical Care Services : Questions and Answers [online]. [s.l.] : [s.n.], 5 May 2005 [cit. 2010-08-09]. Available at: <http://www.fas.org/sgp/crs/misc/IB93103.pdf>.

- government officials, including President and members of Congress, for a fixed payment;
- certain foreign military personnel on active duty in the U.S.

5. 4. 1 Military Health System (MHS)

MHS is a "global medical network within the U.S. Department of Defense providing cutting-edge health care to all U.S. military personnel worldwide". It operates with a $ 50 billion budget and provides highest quality health care to 9.6 million beneficiaries (service members and veterans of the U.S. Army, Navy and Air Force). MHS has 59 hospitals and 364 health clinics, all working with the goal to "serve, protect and treat the service members who defend the U.S."

MHS includes for example army medics on battlefields or medical air crew of Air Force simultaneously treating and transporting injured in the battlefield; military treatment facilities helping service members rebuild their lives after coming home from service; treatment of non-battlefield illnesses; medical research, medical training programs, education and many others. [205]

Active duty service members do not pay anything for military health care in military facilities, except for small daily charge for hospital stays. Other beneficiaries, such as retirees, pay differing amounts depending on when and where they receive care.

5. 4. 2 TRICARE

TRICARE, formerly known as CHAMPUS (The Civilian Health and Medical program of the Uniformed Services), is the worldwide health care program of the U.S. Department of Defense serving active duty service members, National Guard and Reserve Members, retirees, their families, survivors and certain former spouses. It is a component of MHS. TRICARE combines health care resources of the uniformed services with networks of civilian health care professionals, institutions, pharmacies and suppliers. TRICARE is a major source of medical care to the dependents of active duty personnel and military retirees, even though they have to pay co-payments. TRICARE serves approximately 9.6 million beneficiaries.

[205] Military Health System : U.S. Department of Defense [online]. 2010 [cit. 2010-08-09]. Available at: <http://www.health.mil/About_MHS/index.aspx>.

TRICARE beneficiaries have several options how to receive health care. They may choose two types of managed care health plans: HMO and PPO; and regular fee-for-service health plan (reimbursement for portions of the costs of health care received from civilian medical providers). Currently, there are these TRICARE health coverage plans to choose from:

- TRICARE Prime: a managed care option with a PCP offering the most affordable and comprehensive coverage for all beneficiaries not entitled to Medicare due to age (free for active duty service members and their families, others pay fees)
- TRICARE Prime Remote: a managed care option with a PCP for active duty service members and their families who live less than 50 miles or an hour drive from a military treatment facility (free)
- TRICARE Standard and Extra: a fee-for-service plan for all non-active duty beneficiaries in the U.S. (fees apply)
- US Family Health Plan: an additional TRICARE Prime option available through six community-based not-for-profit health care centers within the U.S. (free for active duty family members, others pay fees)
- TRICARE Prime Overseas: a managed care option for active duty service members and their command-sponsored family members living in non-remote overseas locations (free)
- TRICARE Global Remote Overseas: a TRICARE Prime option for active duty service members and their families offered in designated remote overseas locations (free)
- TRICARE Standard Overseas: comprehensive coverage to active duty family members, retired service members and their families and all others who do not/cannot enroll in TRICARE Prime Overseas (fees apply)
- TRICARE For Life: coverage available to all Medicare-eligible TRICARE beneficiaries regardless of age, provided they have Medicare Parts A and B, covering Medicare co-insurance and deductible (free)
- TRICARE Reserve Select: a premium-based health plan for members of the Selected Reserve [206]and their families, who are not enrolled in the FEHBP (fees apply)

Further, TRICARE offers additional pharmacy and dental benefits. [207] [208]

[206] members of the U.S. Army Reserve most readily available for call-up to active duty

[207] BEST, Richard A., Jr. Military Medical Care Services : Questions and Answers [online]. [s.l.] : [s.n.], 5 May 2005 [cit. 2010-08-09]. Available at: <http://www.fas.org/sgp/crs/misc/IB93103.pdf>.

[208] TRICARE [online]. 2010 [cit. 2010-08-09]. New to TRICARE. Available at: <http://www.tricare.mil/mybenefit/NewToTricare.jsp>.

5. 5 Veterans Health Care

5. 5. 1 Veterans Health Administration

Veterans Health Administration is the agency of the U.S. Department of Veterans Affairs (VA), implementing the medical assistance programs of the VA through administration and operation of VA outpatient clinics, hospitals, medical centers and long-term health care facilities (nursing homes). The VA employs approximately 19,000 salaried physicians in 153 medical centers and 900 outpatient clinics. Medical providers in the VA system have usually lower salaries, but they receive additional benefits, such as malpractice immunity or freedom from billing administration. [209] VA uses electronic medical records system (VistA), remotely accessible by every provider, which not only saves costs, but prevents medical mistakes. Veterans of the U.S. armed forces may be eligible for numerous programs and services of the VA. Benefits for veterans include, besides health care, pensions, education, home loan guaranty, life insurance, burial benefits etc. Title 38 of the USC contains legislation for all VA benefits.

Most veterans are eligible for benefits based upon discharge from active military full-time service (members of the Army, Navy, Air Force, Marine Corps, Coast Guard; commissioned officers of the Public Health Service, Environmental Science Services Administration or National Oceanic and Atmospheric Administration) under other than "dishonorable" conditions. VA benefits are usually banned to veterans dishonorably discharged, discharged for bad conduct, in prison or on parole. VA benefits are not provided to any veteran or dependent wanted for an outstanding felony. Certain benefits require service during wartime. VA recognizes Mexican Border War, World War I and II, Korean War, Vietnam War and Gulf War.

5. 5. 2 Health Care Benefits

Health care system for veterans is the nation´s largest integrated health care system, consisting of 1,400 care facilities, including hospitals, clinics, community living centers, domiciliary, readjustment counseling centers and other.

[209] JENSEN, Kristin. Bloomberg [online]. 2 October 2009 [cit. 2010-08-09]. Vets Loving Socialized Medicine Show Government Offers Savings . Available at: <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aLIc5ABThjBk>.

Basically, any person who has served in active military, naval or air service for at least 24 continuous months (or for the full period for which they were called to active duty) and who was not discharged or released under dishonorable conditions is eligible for health care benefits. Also, members of the Army Reserve and National Guard called for active duty may qualify as well.

To receive health benefits, most veterans must apply for enrollment. Some veterans do not need to apply to receive benefits, for example veterans with a "service-connected disability of 50 % and more" or veterans seeking health care only for a service-connected disability. Each veteran is assigned to a priority group during enrollment to balance the demand for VA health care with its resources. In 2010, there are 8 priority groups. For example, Priority 1 consists of veterans with service-connected disabilities of 50 % and more and veterans determined unemployable due to service-connected conditions. Priority 2 are veterans with service-connected disabilities of 30 % - 40 % etc. Priority 7 contains veterans with gross household income below a particular level, who agree to pay co-payments, Priority 8 is assigned to veterans with gross household income above particular level. Service-disabled veterans from Priority 1 and veterans who seek health care only for a service-connected disability have right to priority in scheduling of hospital or outpatient medical appointments.

Women veterans are eligible for same comprehensive VA benefits as males, including primary and specialty care, mental health care and reproductive health care services. Further, they have the rights for contraceptive services, menopause management, mammograms and gynecology and maternity care.

Most veterans must provide information about their incomes and financial situation to determine the priority groups. Some veterans must pay co-payments for health care and medication. At the time of applying for VA medical care, all veterans are required to provide information on their health insurance coverage. VA is then entitled to bill their private health insurance providers for any medical care provided to veterans for non-service-connected conditions, unless the veterans own HDHPs. VA is also not permitted to bill Medicare.

Veterans medical programs include: readjustment counseling services, prosthetic and sensory aids (glasses, hearing aids), home improvements up to $ 4,100, services for blind and visually impaired veterans (adjustment to blindness training, vehicle grant,

home improvement, guide dog), mental health care treatment, suicide prevention programs, therapeutic work restoration programs, dental health care, nursing home care etc. Some special eligibility programs exist as well, such as Special Eligibility Program for Children with Spina Bifida. VA reimburses, under certain conditions, for emergency medical care in non-VA facilities. [210]

5. 6 Indian Health Services [211]

The Indian Health Services (IHS), an agency of the HHS, is responsible for providing comprehensive federal health services to 564 federally recognized tribes of American Indians and Alaska Natives in 35 states (approximately 1.9 million people). It is also one the only two government agencies in the U.S., that are obliged to use "Indian Preference" in hiring. A qualified Indian applicant has legal preference in hiring over equally qualified non-Indian. The relationship between the federal government and Indian Tribes was established in 1787; and is based on the Article I, Section 8 of the Constitution and numerous treaties, laws, Supreme Court decisions and Executive Orders.

Federal government has a legal obligation to provide, among others, health care to American Indians and Alaska Natives. The trust relationship, a political relationship further distinguishing Indians from racial classification, has been defined in case law (Cherokee Nation v Georgia, 1831) and statutes. Treaties between the U.S. government and federal tribes call for the provision of medical services, physicians´ services and hospital care for Native Americans. For example, the Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976 provide specific legislative authority for Congress to appropriate funds specifically for the health care of Indians. Since 1976, the Indian Health Care Improvement Act has been reauthorized four times by Congress. In 2001, the law expired and since then, federal government has been working with various Native Americans groups to reauthorize and modernize the law, with the primary focus on prevention. Health care reform of 2010 provides authorization for

[210] U.S. Department of Veterans Affairs [online]. 2010 [cit. 2010-08-10]. Federal Benefits for Veterans,Federal Benefits for Veterans, Dependents and Survivors. Available at: <http://www1.va.gov/opa/publications/benefits_book.asp>.

[211] The Indian Health Service : The Federal Health Program for American Indians and Alaska Natives [online]. 2010 [cit. 2010-08-10]. Available at: <http://info.ihs.gov/>.

hospice, assisted living, long-term and home and community based care; updates current laws regarding reimbursements from Medicare, Medicaid and CHIP by Indian health facilities; allows tribes to purchase health benefit coverage for IHS beneficiaries, under certain conditions even the FEHBP health coverage; authorizes IHS to share medical facilities with VA or permanently reauthorizes the IHS. [212]

The Native Americans (including Alaska Natives) are still citizens of the U.S. and thus may participate in any private, state or public health benefit programs. But in addition, they also have rights to federal health care services through the HHS. Indian health care policies or budgets are always consulted with Indian Tribes. The IHS has annual budget of about $ 3.5 billion.

While the IHS tries to provide comprehensive health care (dental coverage included) directly through the IHS or indirectly through tribally contracted hospitals, health centers, school health centers and health stations, the capacity of these medical facilities is very limited. Currently, there are about 700 health care facilities (mostly in isolated rural areas) in 36 states, 64 % owned by government, 36 % by tribes. The IHS either hires its own staff and decides what services will be provided in the IHS facilities, or it contracts with tribes/tribal hospitals to provide health care to Native Americans. In the latter, the contracts with tribes run under the Indian Self-Determination and Education Assistance Act of 1975. The IHS funds the health care delivery, but it is the tribes that decide what services will be provided.

Despite the seeming complex federal health care, health disparities between Native Americans and the rest of the Americans are alarming. Native Americans die at a 500 % higher rate than other races from tuberculosis, 519 % higher rate from alcoholism, 79 % higher rate from suicide or 195 % higher rate from diabetes. The disparities in health status are directly affected by access to health care services. Sadly, most facilities are overcrowded hospitals in old buildings with more than 12 years old equipment. Medical and laboratory equipment has average life of 6 years. Unfortunately, the IHS health programs are the only source of health care for many Indians, especially for those living in isolated areas.

[212] NAING, Eric. Open Congress [online]. 8 April 2010 [cit. 2010-08-12]. Native American Health Care Reform . Available at: <http://www.opencongress.org/articles/view/1798-Native-American-Health-Care-Reform>.

6. HEALTH CARE REFORM 2010

In March 2010, the U.S. Congress passed and President Barrack Obama signed the Patient Protection and Affordable Care Act into law. It has instantly become one of the most significant pieces of federal legislation in the nation´s history since it overhauls the nation´s health care system and aims to guarantee access to health insurance for tens of millions of Americans. The Health Care and Education Reconciliation Act of 2010 complements the health care reform by amending the PPACA.

6. 1 Background and Constitutionality [213]

The Democrats have longed for universal access to health insurance for a long time. Generally all Democratic Presidents, starting with Franklin D. Roosevelt, have aimed for universal and affordable health care system. President Bill Clinton suffered the biggest failure with his ambitious proposal. President Obama indicated the scope of his ambitions when he asked Congress to put aside $ 600 billion in the 2010 budget for future efforts to remake health care system. Democrats then started to work on three separate paths how to achieve health care system changes. Republicans who, unlike Democrats, rely more on the market and less on government, worked on separate health care bill as an alternative to Obama´s bill. However, their proposals would not provide health coverage to anything like the number of people that would gain health insurance under Democrats´ proposals.

On 22 February 2010, President Obama released his bill. The bill intended to expand coverage for the uninsured while reducing insurance premiums and imposing "common sense rules of the road" for the insurance companies, including banning the popular practice of denying coverage to or discriminating people with pre-existing health conditions. Also, more money would flow to states to help them pay for public health programs and cover the "doughnut hole" in Medicare Part D. On 25 February 2010, Democrats and Republicans met for a televised health care reform debate across

[213] The New York Times [online]. 1 July 2010 [cit. 2010-08-13]. Health Care Reform. Available at: <http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html?offset=0&s=newest>.

the street from White House. Democrats tried to convince Republicans that the two parties were actually very close with their proposals and that the Democrats´ proposal would be accepted by mainstream voters. Republicans argued that the gap between them and Democrats was too vast and the bill was out of touch with what the country wanted and more importantly, what it could afford. The biggest disagreement was actually not the government intervention in the private insurance market, although Republicans strongly oppose any market regulations, but the fact that Republicans believed there was no way the country could afford huge public programs under Democrat´s reform to cover for more than 30 additional million people over the next decade, when even then the financing of public programs already struggled. The long legislative battle over the health care bill culminated on 21 March 2010, when the House of Representatives approved the bill.

Immediately after President Obama signed the health care bill into law on 23 March 2010, 21 states [214] filed lawsuits in federal courts. The states and attorneys general hope that the U.S. Supreme Court will ultimately strike down the law and once again clarifies the limits on Congress´s authority to regulate interstate commerce. The main argument is that "the commerce clause of the U.S. Constitution cannot be interpreted as allowing federal government to impose penalties on Americans for refusing to buy a product", or in other word, for "an absence of commerce". Basically they say that the federal government does not have the power to mandate Americans to obtain private health insurance (this is called the "individual mandate"), let alone to penalize them. The expansion of commerce clause on the economic inactivity is unprecedented. Congress has never before used the commerce clause to mandate that an individual engages in economic transaction with a private company. The DOJ has countered that the insurance regulation fits within the Supreme Court´s interpretation of interstate commerce. The choice of people not to obtain health coverage is an active decision and not inactivity. By refusing to obtain health coverage people make an active decision to pay for health care out-of-pockets. And because most Americans cannot afford out-of-pocket payments for surgeries and hospitalization, their decision not to obtain health coverage and remain uninsured shifts their health care costs to hospitals,

[214] Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, South Dakota, Pennsylvania, Texas, Utah, Virginia and Washington

taxpayers and commercial policy holders. Ultimately, these decisions lead to rising health care costs for everyone. States oppose that health care overhaul should address the "outrageously high health care insurance costs". Instead, the 2010 health care reform brings new mandates, paperwork and taxes and increases the costs of conducting business once again.

Virginia filed a separate suit arguing that the new law clashes with a state law exempting Virginians from federal fines to be imposed for not having health insurance.[215] Since under 10th Amendment of the U.S. Constitution any federal law pursuant to one of the powers of the Constitution is supreme to state law, this case´s success also depends on whether court rules that Congress had the power to adopt the health care reform law or did not. Obama´s administration filed for a dismissal of this case before hearing merits. But on 2 August 2010, the U.S. District Court judge on case ruled that Virginia had a right to sue to invalidate the health care reform law and the case could proceed to a hearing on the merits even though the federal law had not yet taken full effect. A legitimate claim is present because the issues are already fully developed on the case (the state law is in effect). The legal issue is "*whether or not Congress has the power to regulate and tax a citizen´s decision not to participate in interstate commerce (by choosing not to buy health insurance)*". The judge thus, in effect, agreed to rule on the constitutionality of the health care reform in the future. [216] Other states still need to persuade the respective courts they have "standing" (a right to sue) as well, but by some other paths since Virginia´s case is specific in the fact that a state law conflicting with federal law, even though not in effect, has already existed.

All the health care reform cases will eventually probably end up in the Supreme Court through appeals; hence a final decision may be made as late as 2013. [217]

The PPACA is estimated to provide coverage to more than 30 million uninsured who currently lack health insurance. Furthermore, under PPACA, 16 million people will be added to Medicaid coverage, low-income and middle-income people will receive private health insurance subsidies, insurance companies will be prohibited from denying

[215] BROWN, Tom. REUTERS [online]. 14 May 2010 [cit. 2010-08-19]. States joined in suit against healthcare reform. Available at: <http://www.reuters.com/article/idUSTRE64D6CJ20100514>.

[216] a summary judgment hearing followed by the decision is scheduled on 18 October 2010

[217] FIELD, Abigail. Daily Finance [online]. 2 August 2010 [cit. 2010-08-19]. Health Care. Available at: <http://www.dailyfinance.com/story/virginias-health-care-reform-lawsuit-judge-ruling/19577776/>.

health coverage based on pre-existing conditions etc. The federal government will spend about $ 938 billion on the PPACA provisions in the next 10 years, but over the same time, PPACA implementation should reduce the federal deficit by $ 138 billion.

Who will pay for the PPACA? As always, the taxpayers. Several taxes are being expanded (Medicare tax, certain excise tax) to pay for the costs and a new 10 % excise tax on indoor tanning services has been established.

The government has adopted set of health reform associated regulations, including a patient´s bill of rights and has persuaded the insurance companies to change their policies to comply with the law even though the law does not yet require these changes for several years. Official websites have been made to inform people about health care reform requirements.

6. 2 Major Changes [218]

The PPACA, as the basis of health care reform of 2010, puts in place comprehensive health insurance reform that is expected to hold insurance companies more accountable, lower health care costs, guarantee more health care choices and control over health coverage and enhance the quality of health care for all Americans. While most changes will start in 2014, several major provisions come into effect immediately. Once fully implemented, the PPACA promises Americans will have gained access to affordable health care coverage. Opponents are convinced that the PPACA mandates will only result in higher price of insurance and no real changes will be achieved.

The PPACA is projected to reduce the premium costs for millions of Americans and small business owners who have been struggling to pay for health care coverage in past years. As a result, approximately 32 million uninsured Americans should be able to receive health coverage once the price for health insurance decreases. To help lower the costs, the PPACA:

- sets up a new competitive health insurance market by creating state health insurance Exchanges

[218] Health Care.gov : Understand the new law [online]. 2010 [cit. 2010-08-13]. Available at: <http://www.healthcare.gov/law/introduction/index.html>.

- holds insurance companies accountable and banns many types of abuses of insurance industry, for example denials of care or discrimination of people with pre-existing health conditions.
- stabilizes the budget and economy by reducing the deficit by $ 138 billion over the next 10 years and by more than $ 1 trillion over the second decade due to cuts in government spending and waste, fraud and abuse elimination

The PPACA was already amended by the HCERA. The HCERA is divided into two titles, the first one addresses health care reform, the second one student loans reform. The HCERA made number of changes in the initial PPACA, e.g. lowered the penalty for not having health insurance from $ 750 to 695, aimed for closing Medicare prescription drug coverage gap by 2020, promoted financial incentives for fighting waste, fraud and abuse, increased tax credits to buy insurance etc. The following health reform changes come from the PPACA as amended by the HCERA.

We provide brief description of major changes in the health care system due to health care reform. Most changes concern one of the following health care reform goals: (1) improving health care quality and lowering costs; (2) holding insurance companies accountable; (3) increasing access to affordable care; and (4) implementing new consumer protection provisions.

6. 2. 1 Provisions Effective Immediately

These major changes take place during 2010:

- insurance companies are prohibited from denying coverage of children under the age of 19 based on pre-existing conditions
- insurance companies are prohibited from rescinding coverage (denying payment for services once an insured gets sick on the grounds of a formal or technical mistake or innocent error on an insurance application)
- insurance companies are prohibited from imposing lifetime limits on essential insurance benefits, such as hospital stays coverage; annual limits on the amount of insurance coverage will be restricted until 2014, then banned
- establishment of external review process and appeal process for consumers regarding insurance claims
- establishment of an easy-to-use website for consumers to compare health coverage options

- up to 4 million of small businesses receive tax credits to help provide insurance benefits for employees
- seniors who hit "doughnut hole" in Medicare Prescription coverage receive a $ 250 rebate check
- all new health plans must cover preventive services, such as mammograms, free of charge
- creation of Prevention and Public Health Fund to help keep Americans healthy (from smoking to obesity)
- implementation of new procedures in the health care fraud and abuse combat
- establishment of a new federal or state "Pre-existing Condition Insurance Plan" to provide coverage option to Americans uninsured due to a pre-existing condition
- young adults up to 26 years of age can stay on their parent´s health insurance plan
- expanding coverage for early retirees who do not qualify for Medicare due to age by providing financial help for employment-based health plans to cover retired between 55 and 65 years of age (until insurance Exchanges are created in 2014 to offer affordable health coverage for these people)
- rebuilding of primary care medical personnel through scholarships and loan repayments program for primary care specialties
- insurance companies need to justify premium rates increases, otherwise they will be banned from participating in insurance Exchange starting 2014
- more federal funds for states to cover additional people in Medicaid

6. 2. 2 Provisions Effective From 2011

- senior who reach the coverage gap (doughnut hole) in Medicare Part D get a 50 % discount on Medicare covered brand-name prescription drugs; later, additional savings will be introduced on both generics and brand-name drugs until the coverage gap closes in 2020
- certain free preventive care for seniors on Medicare (wellness)
- establishment of a new Center for Medicare and Medicaid Innovation to test new ways of delivering health care
- improving health care for high-risk seniors after they are discharged from hospital to prevent their readmission
- the Independent Payment Advisory Board starts submitting proposals to Congress and the President on how to reduce waste costs and improve health care to high-quality health care in Medicare

- states may offer home and community based services to disabled under Medicaid as an option along institutionalized nursing care in nursing homes
- insurance companies must use at least 80 % of collected premiums to pay for health care services or provide better benefits; if an insurance company fails to do so due to for example high administration costs, it must provide rebates and discounts to its customers
- reducing costs in Medicare Advantage plans

6. 2. 3 Provisions Effective From 2012

- financial incentives for hospitals that improve the quality of health care for Medicare enrollees
- financial incentives for physicians to create Accountable Care Organizations that coordinate patient care, improve quality, prevent diseases and reduce unnecessary hospital stays in order to help health care system save money; the Accountable Care Organization then keep part of money they have helped save
- implementing electronic health records system to reduce paperwork and administrative costs
- any federal government health program must collect racial, ethnic and language data to address and reduce health disparities between various groups of people
- creating voluntary long-term care program (CLASS) to provide cash benefits to adults who become disabled

6. 2. 4 Provisions Effective From 2013

- additional funding for state Medicaid programs that cover preventive services for patients free of charge or at minimum cost
- encouraging of payment "bundling" to make medical providers want to be paid based on an "episode of care" rather than on fragmented individual services and tests
- states must pay primary care physicians within Medicaid system at least 100 % of Medicare payments rates to balance the future increase of Medicaid patients (Medicare payment rates are generally higher that Medicaid payment rates)
- states receive two more years of additional federal funding to continue CHIP coverage for those children who are not eligible for Medicaid

6. 2. 5 Provisions Effective From 2014

- insurance companies are strictly prohibited from refusing to sell or renew coverage policies due to an individual´s pre-existing condition
- small group and individual health insurance companies are prohibited from charging higher premiums due to gender or health status
- no health insurance policies may impose annual limits on the amount of coverage an individual may receive
- insurance companies are prohibited from dropping or limiting health coverage to those who participate in clinical trials treating cancer or other life-threatening diseases
- tax credits for middle class people (above 133 % and below 400 % of poverty level) to help them afford health insurance coverage
- establishment of American Health Benefit Exchanges (separately for individuals and separately for small businesses), where individuals and small businesses up to 100 employees can buy affordable and qualified health insurance plans (when for example employer does not provide health insurance); all Congress members are obliged to buy health insurance on Exchanges as well; four types of standardized health coverage plans varying in premiums and benefits will exist; employers of more than 50 employees who do not offer health coverage and their employees thus must buy insurance on the Exchange will pay penalty of USD 2000 per every employee (in excess of 30 employees) [219]
- additional tax credits for small businesses to provide health insurance to its employees
- all Americans earning less than 133 % of the poverty level are eligible to enroll in Medicaid; states receive 100 % federal funding for the first three years to pay for expansion of Medicaid
- individuals who can afford health insurance must buy health insurance, otherwise they must pay a penalty of $ 695 or 2.1 % of household income to help offset the costs of caring for uninsured Americans; some exemptions apply, e.g. financial hardship or religious objection to health coverage (this provision is referred to as the "individual mandate")
- employees who cannot afford employer-sponsored health insurance may take employers´ contribution and go buy an affordable health insurance on the Exchange

[219] The Kaiser Family Foundation. Focus on Health Reform : Summary of Coverage Provisions [online]. [s.l.] : [s.n.], 2010 [cit. 2010-08-13]. Available at: <http://www.kff.org/healthreform/upload/8023-R.pdf>.

6. 2. 6 Provisions Effective From 2015

- physicians are paid based on value (quality of care) and not on volume; those who provide lower quality care receive lower payments than those with high-care quality

As noted in previous chapters, health care reform is expected to create a better health care system with affordable health insurance while at the same time lowering rising health care expenses. Since most provisions have not come into effect yet, it is hard to assess whether the health reform provisions fulfill its goals and move the U.S. towards more universal and balanced health care system with the minimum number of uninsured. While some reform elements are highly appraised, such as banning discrimination of pre-existing conditions or expansion of public health programs, others raise concern within general public. The government´s more and more stringent intervention on the "used-to-be-free" U.S. insurance market is definitely among the most controversial issues. However, historically, only few reforms have had strong public supports and so far it seems that the Obama´s health care reform does have many supporters and could at least really stir up the steady health care industry waters. Only the time will tell whether the overall promising changes will really make a positive difference in the system or whether the critics were right once again and the reform makes promises that can never come true.

CONCLUSION

The thesis is supposed to provide a general description of the U.S. health care system, including legislation, to enable readers to gain basic knowledge of how the whole system operates. The key question raised in the introduction is how does the U.S. system of health care delivery and health insurance really work? The thesis analyzed cardinal points and issues associated with health care to fulfill the objective.

The thesis comprises six chapters. In the first chapter, we introduced the health care and health insurance industry to constitute a basis for additional information on the system´s major parts. The history of health care and health insurance provided answers to those wondering why a universal health care system had never been established in the U.S. We learned that the U.S. health care system is enormously compound multi-payer mechanism, financed through both private and public funds. Although it is not exactly universal, it contains important social elements expanding its services to low-income, elderly, disabled or otherwise unprivileged population.

The second chapter centers on health care law. Introduction to the U.S. law system precedes exploring specific health care law issues, such as medical malpractice, fraud and abuse of health care, antitrust and monopoly law and right for treatment and access to health care. The most important law of all, the U.S. Constitution, delimitates the relations between the federal and state governments. Simply said, where Constitution (i.e. federal government) speaks, no state law may contradict it. However, occasional collisions occur and the Supreme Court must come in place to set and clear the boundaries once again. The alleged unconstitutionality of health care reform has been one of the most recent disputes between state and federal governments. A lot of people think that the health care in the U.S., especially the private one, is free from any regulation. The opposite is true. The health care industry is the most heavily regulated industry in the U.S. and private health insurance providers, including employers, are subject to enormous amount of rules. The thesis points out the most important health care and health insurance related laws. States are primarily responsible for preserving public health, but federal government provides guidelines and laws to ensure some consistency, especially in matters with cross-state effects.

The third chapter commences the main part of the thesis, health insurance and its regulation, which continues through chapters four and five, where private and public health insurance systems are dealt with separately. The U.S. is characterized by co-existence of public and private health insurance. While private health insurance is based on commercial insurance contract, public health insurance operates differently. There are several ways how to obtain health insurance. The U.S. is generally very liberal, thus it is the individual´s option to obtain health insurance. At least until the "individual mandate" of the 2010 health care reform comes into effect, when this option transforms into an obligation. Those who cannot afford private health coverage may qualify for public health insurance. However, only a small part of people actually pays the whole private health insurance premiums. Majority receive large contributions from their employees, which are encouraged to offer health coverage through a system of tax subsidies. In contrast with popular beliefs, the U.S. public health insurance system actually provides access to health care to tens of millions of unprivileged, chronically ill, indigent, disabled or elderly Americans. The alleged masses of uninsured form about 15 % of the population. The majority of the uninsured are eligible for some form of public help, but are unaware of it or choose not to take advantage of it. Certainly there are people who really lack access to health insurance, but even those have rights for free health care in public or charity hospitals. Further, health care in emergency situations must be provided by nearly all hospitals to anyone in need, regardless their funds for reimbursement. On the other hand, it is true that medical expenses are among the top reasons people lose homes due to foreclosure and approximately 50 % of personal bankruptcy filings occur due to unpaid health care bills.

Still, overall, the U.S. spending on public health care is definitely more than the spending of most Western Europe countries, and we cannot agree with those opinions contending that the health care in the U.S. is completely private. Almost one third of the population is enrolled in public programs. The 2010 health care reform further expands the public health insurance programs to encompass even more people under the public coverage.

The Americans may choose from a variety of health coverage plans (this option exists within both public and private health insurance system) the one that best covers their needs. As mentioned above, a large amount of rules and laws apply in the industry.

Most of them are primarily designated to affect, directly or indirectly, health insurance or health coverage plans. For example, there are state and federal requirements for the minimum content of every plan, known as the coverage mandates, enacting which benefits the plan must compulsorily cover. Although the goal of coverage mandates is honorable and ensures certain consistency among various health plans, imposing coverage requirements on health plans results essentially only in the increase of price of health care. Since the health plans are mandated to pay for more health benefits by law, premiums for these kinds of coverage must logically rise. Moreover, the standardization of private health plans towards better benefits eliminates cheaper, less comprehensive health insurance options off the market, and may truly be one of the reasons why some people are uninsured. There are people who do not qualify for public healthcare because their income is above poverty level. But at the same time, their earnings are not high enough to purchase comprehensive health plan that covers all possible health care benefits, which the majority does not need. Such people would gladly buy a less expensive health plan with basic benefits, but no such exist on the market. Thus, they join the uninsured "masses" as a result of government´s original admirable intention to provide better health coverage for all. The health care reform certainly does not reduce the number of mandates (it even adds several more), but it does address the mandate issue by providing tax credits and subsidies to middle class people to make comprehensive health insurance more affordable.

The rising cost of health care delivery and health insurance premiums is probably the number one problem of the U.S. system. It is the grounds for other problems of the U.S. health care as well, because financing links all the parts of U.S. health care system. The thing is that even the experts disagree on how to control escalating health care spending. While some favor price controls, strict budget and more government regulation, others believe the power of free market competition will solve the problems. There are also persons who are convinced that if only the Americans adopted healthy lifestyles, health care costs would decrease eventually without further government action. The U.S. has been using the "more government intervention" approach recently. However, so far the governments have achieved rather increases in costs due to their measures as opposed to any real savings. This is not the consequence that people think of when they call for heavier regulation and more restrictions on their

private health insurance. Economists use the phrase "there is no free lunch" to express that there is a cost to everything, even if it cannot be seen right away. At the end, it is the people who will pay for additional regulation or more universal coverage, either in the increase of premium prices or through taxes, because the government cannot just print the money to finance the escalating costs.

The Obama´s health care reform further expands the federal regulation. Nevertheless, the reform seems to have a very comprehensive plan how to achieve the cost reduction while providing higher quality health care to almost all Americans. The major provisions of the health care reform law are presented in the final, sixth chapter of the thesis. We will have to wait and see whether this, rather contradictory promise, makes some real difference at the end. The health care reform will be fully in effect from 2014.

The thesis aimed to point out some of the major issues associated with health care so that the readers would be able to form their own opinions about whether the system works as it should or not. Hopefully by now, some already made up their mind. Definitely there are serious problems that must be dealt with, but in general, the system is not as bad as it is often presented. On the contrary, the successful co-existence of private and public entities operating alongside in the health care industry is actually quite inspiring on many levels, particularly with respect to the Czech Republic´s constant fear that permitting private elements and competition in the health care "market" would result in permanent deterioration of the system.

The U.S. system as a whole would not work in the Czech Republic. It is just not one of the typical "universal free-of-charge highest-quality health care for everyone" types of health systems the Europeans are used to; and although we are convinced there are major advantages for the consumers related to the existence of private health insurance as an alternative or a complement to public health insurance (arising simply out of competition of health insurance companies on the market), we do not want to recommend these "system changes" in this paper as they currently lack the political support and would not be accepted anyway. Instead, we focus on recommendations concerning "acceptable" elements of the U.S. system.

It is irrefutable that implementing components associated with each individual´s cost-sharing and co-financing would bring more funds into the Czech Republic health

care system. More importantly, it would raise the awareness about how much the health care services actually cost. We believe that especially some variation of the "consumer driven health care" concept would be a good start for raising awareness about actual health care costs in the Czech Republic. The CDHC is designated to reduce health care spending in general by providing financial incentives to health care consumers (the insured). In the U.S. under CDHC, a consumer opens a special saving account with tax benefits from which he/she pays the out-of-pocket costs for health care services, up to the amount of a deductible of health insurance. Health insurance associated with a saving account starts reimbursing the health care services when a deductible is exceeded, thus covering for expensive services only and leaving the payment for routine inexpensive services to the consumer. The consumer uses credit on a saving account to cover these services, hence deciding by him/herself what health care services to "buy" and where to buy them. Because it is the consumer´s own money spent on health care, he/she naturally tries to save as much as possible by optimizing own health care. Certainly we cannot expect people to be able to make informed decisions about specialized health care; therefore such health care delivery (and the coverage thereof) is left to professionals and consumers manage only routine, inexpensive health care. Similar tax-benefited saving accounts could be implemented in the Czech Republic as a way for the people to pay the so called regulatory fees for certain health care services. As health care services where regulatory fees apply will probably be expanding, the existence of these accounts would perhaps increase the willingness of the people to share the costs in the health care and thus relieve the public funds of health care costs for banal, petty services. The CDHC saving accounts could be established without any major implementation costs and could work almost instantly within the current Czech Republic health care system, as well as within the future reformed health care system where cost-sharing will be much bigger.

Another U.S. health care concept transferrable to the Czech Republic is the existence of various health plans within the U.S. private and public health insurance systems. In the Czech Republic, only one health plan exists and covers all health care services (except elective) from public health insurance. No "standard of health care" is defined. All people pay the same health insurance premium (in the form of social insurance) and all are entitled to all health care services covered by the state health

insurance. Consequently, the financing of health care industry struggles, because the price of the insurance neither depends on the benefits provided by a health plan nor is it derived from the individual risk factors of each person, and thus does not reflect the costs of individual´s health care at all. If there was a selection of health plans within the health insurance, people would be able to choose a health plan according to their needs and preferences and both the people and the state would save money for health care. For example, even if only two health plans existed, let´s say "standard" (covering for all the standard health care as defined in the law) and "advanced" (covering for all the standard health care plus above standard services, such as single room in case of hospital stays or hip replacement made out of lighter material), people not requiring above standard services could pay lower social insurance premiums for standard health plan than people wishing for the above standard services. The price of health insurance would then reflect at least the cost of health care services included in the respective health plan. The above standard services may be purchased under current health care system as well, but the lack of legal definition of what is standard makes the system anything but transparent and very vulnerable to corruption. What one hospital considers standard, the other requires payment for. The patients then do not know what to expect and legitimately loose the trust in the system.

These are only a few ideas how to improve the Czech health care delivery using some U.S. health care system elements. Surely, there are many more possibilities. However, the increasing amount of patients´ participation (not only financial, but in management and delivery of health care as well) in the process of operation of their own health care could be the key to improvement of the universalized system of the Czech health care.

We understand that when the taxes or social insurance silently shorten our disposable income, it makes the impression that the Czech Republic really does have a "universal free-of-charge highest-quality health care for everyone" system. And maybe it does, for now. So why change that. But serious issues in the current Czech health care operation have been occurring, especially related to financing. Tax rates and social insurance rates do have limits and cannot be raised infinitely to finance health care for everyone free of charge. What happens when the Czech Republic just cannot afford the highest-quality health care for everyone anymore? Do we really want to find out? Isn´t

it better to make some precautions now? Let´s all finally accept responsibility for our own health care and prevent the Czech health care system from collapsing before it is too late.

LIST OF ABBREVIATIONS

AAAL	the American Association for Labor Legislation
AMA	the American Medical Association
ARRA	the American Recovery and Reinvestment Act of 2009
AWPs	any willing provider laws
CAA	the Clayton Anti-Trust Act of 1914
CDHC	Consumer Driven Health Care
CHIP	the Children´s Health Insurance Program
CHIPRA	the Children´s Health Insurance Program Reauthorization Act of 2009
COBRA	the Consolidated Omnibus Reconciliation Act
DOJ	the U.S. Department of Justice
EMTALA	the Emergency Medical Treatment and Active Labor Act of 1985
ERISA	the Employee Retirement Income Security Act of 1974
FEHBP	Federal Employees Health Benefit Plan
FMLA	the Family and Medical Leave Act of 1993
FSA	Flexible Spending Account
FTC	Federal Trade Commission
GDP	Gross National Product
GLBA	the Gramm-Leach-Bliley Act of 1999
HCERA	the Health Care and Education Reconciliation Act of 2010
HDHP	High Deductible Health Insurance Plan
HHS	the U.S. Department of Health and Human Services
HIPAA	the Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment Program
HMO Act	the Health Maintenance Organization Act of 1973
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
HSR	the Hart-Scott-Rodino Antitrust Improvement Act of 1976
IHS	the Indian Health Services
IOM	the Institute of Medicine

IPA	association of independent physicians/independent practice association
IRC	the Internal Revenue Code
MHPA	the Mental Health Parity and Addiction Equity Act of 1996
MHS	Military Health System
MHSS	Military Health Services System
MMA	the Medicare Prescription Drug, Improvement, and Modernization Act, also known as the Medicare Modernization Act of 2003
MSA	Medical Savings Account
NAIC	the National Association of Insurance Commissioners
NSPD	Network of Patient Safety Databases
PCP	primary care physician
PDP	Medicare Prescription Drug Plan
POS	Point-of-Service Plan
PPACA	the Patient Protection and Affordable Care Act of 2010
PPO	Preferred Provider Organization
PSO	Patient Safety Organization
PSQIA	the Patient Safety and Quality Improvement Act of 2005
PSWP	Patient Safety Work Product
SAA	the Sherman Anti-Trust Act of 1890
The U.S.	the United States of America
USC	the United States Code
USERRA	the Uniformed Services Employment and Reemployment Rights Act of 1994
VA	the U.S. Department of Veterans Affairs

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SUMMARY IN CZECH / TEZE V ČESKÉM JAZYCE

Téma diplomové práce: Zdravotní péče ve Spojených státech amerických

Spojené státy americké, federativní prezidentská republika složená z padesáti států, jsou třetí nejlidnatější (přes 309 milionů obyvatel) a třetí největší zemi na světě (rozloha 9,83 km^2). Ekonomika Spojených států je největší na světě a vyrobí zhruba čtvrtinu celosvětového hrubého domácího produktu, tj. hrubý domácí produkt Spojených států činí přibližně 14,4 bilionům amerických dolarů. Každý rok na americké zdravotnictví připadne kolem 16 % až 17 % hrubého domácího produktu (2,3 bilionu amerických dolarů), což z něj dělá téměř nejdražší zdravotní systém na celém světě. I náklady na související administrativu jsou přibližně šestkrát větší než v jakémkoliv státě západní Evropy.

Americký systém zdravotní péče je často kritizován jako příliš komerční, diskriminační a téměř neregulovaný. Předkládaná diplomová práce popisuje fungování komplexního systému zdravotní péče v USA s cílem umožnit čtenářům proniknout hlouběji do základů systému a jeho hlavních institutů. Po přečtení práce by čtenáři měli být nejen schopni pochopit fungování systému, ale i samostatně zhodnotit výhody a nevýhody, případně spravedlnost a efektivnost systému, a učinit si vlastní obrázek o tom, zda je kritika systému oprávněná či nikoliv.

Práce se skládá ze šesti kapitol: (1) přehled systému zdravotní péče a zdravotního pojištění včetně historie; (2) právo zdravotní péče; (3) typy plánů zdravotního pojištění; (4) soukromé zdravotní pojištění; (5) veřejné zdravotní pojištění; (6) reforma zdravotní péče z roku 2010. Hlavní část práce tvoří kapitoly 3 až 5, tj. právní úprava zdravotního pojištění a plánů zdravotního pojištění, a to jak státní, tak federální. Nemalá část práce je věnována i problematice „medical malpractice“ (zanedbání povinné péče) a „health care fraud and abuse“ (podvody a zneužívání systému zdravotní péče). Poslední kapitola o reformě zdravotní péče umožňuje nahlédnout do blízké budoucnosti fungování systému. V závěru práce nabízí několik doporučení pro Českou republiku. Informace obsažené v diplomové práci odpovídají právnímu stavu v srpnu 2010.

První kapitola představuje základní fakta o systému zdravotní péče a zdravotního pojištění. Spojené státy v současné době nemají univerzální zdravotní systém, ani univerzální všeobecné zdravotní pojištění. Spojené státy dokonce jako jediná vyspělá země na světě negarantují svým občanům právo na přístup ke zdravotní péči. Ústava Spojených států o zdravotní péči zcela mlčí. Vzhledem k tomu, že federální vláda může uplatňovat federální moc (a tedy přijímat federální zákony) pouze v mezích taxativně stanovených Ústavou, úprava a regulace zdravotní péče a zdravotního pojištění zůstává primárně na jednotlivých státech. Federální regulace přichází na řadu až v případech, kdy záležitosti týkající se zdravotní péče či zdravotního pojištění překročí svým vlivem či efektem hranice státu.

Zdravotní péče je ve Spojených státech zajišťována jak soukromými, tak veřejnými subjekty. Tomu odpovídá i její financování, kdy se skládají soukromé i veřejné fondy. Soukromé financování (a soukromá zdravotní péče a pojištění) převažuje, nicméně i tak Spojené státy vynaloží nesrovnatelně více prostředků na provoz veřejného zdravotní pojištění a veřejné zdravotní péče ve srovnání s většinou vyspělých zemí.

V systému zdravotní péče se pohybuje pět typů subjektů. Jednotlivci; obchodní společnosti („businesses“); soukromí pojistitelé (pojišťovny); vláda a poskytovatelé zdravotní péče. Jednotlivci a obchodní společnosti odvádějí daně vládě a pojistné soukromým pojistitelům. Zároveň se jednotlivci podílejí na spolufinancování vlastní zdravotní péče formou přímé úhrady části nákladů za poskytnuté služby (tzv. spoluúčast) přímo poskytovatelům zdravotní péče z vlastních zdrojů. Vláda platí soukromým pojistitelům pojistné za své, federální, zaměstnance a současně z daní financuje subsystémy veřejného zdravotního pojištění. Poskytovatelé zdravotní péče na oplátku poskytují zdravotní služby soukromým a veřejným pojištěncům či nepojištěným jednotlivcům (za úhradu). Soukromé pojišťovny z nashromážděného pojistného uhradí poskytovatelům zdravotní péče náklady zdravotní péče poskytnuté pojištěncům pojišťoven.

V současné době poskytuje zdravotní služby téměř 590 tisíc institucí, od malých ordinací praktických lékařů, přes centra dlouhodobé péči (např. domovy důchodců), po obrovská zdravotní specializovaná zdravotní centra. Zdravotnictví ve Spojených státech není bezplatné. Pokud občané nemají zdravotní pojištění, musí veškeré náklady

zdravotní péče hradit z vlastních prostředků. Druh zdravotního pojištění, a zejména typ plánu zdravotního pojištění určuje, jaké zdravotní služby budou pacientům poskytnuty a proplaceny. Většina pojištění hradí ambulantní i lůžkovou, preventivní, rutinní a pohotovostní péči v nemocnicích a služby poskytované soukromými lékaři. Některé plány kryjí i výdaje spojené s léky na předpis či zubní lékařství. Na rozdíl od České republiky většina plánů zdravotního pojištění vyžaduje spoluúčast pacientů při hrazení zdravotních služeb a výkonů. Mechanismus spoluúčastí se liší plán od plánu, nicméně obecně pojištěnci participují na nákladech buď formou fixních poplatků (např. za návštěvu lékaře) nebo určitým procentem z ceny výkonu či služby. Není výjimkou, že zdravotní pojišťovna začne proplácet zdravotní služby či výkony až po dosažení či překročení určité výše výdajů, které pacient zaplatil doslova z vlastní kapsy. Tento limit se označuje jako „deductible“. Teprve po dosažení limitu začne pojišťovna hradit poskytnutou zdravotní péči. I po dosažení limitu je ale pacient většinou povinen podílet se na nákladech své péče.

Co se týče systémů zdravotního pojištění, ve Spojených státech vedle sebe existují soukromé zdravotní pojištění a veřejné (vládní) zdravotní pojištění. Přibližně 85 % populace je pojištěno. Zbylých 15 % zdravotní pojištění z různých důvodů nemá.

Soukromé zdravotní pojištění dělíme na skupinové nebo individuální. Oba typy soukromého pojištění spravuje soukromá pojišťovna, případně zaměstnavatel (pokud provádí tzv. samopojištění - „self-insurance“). Rozdíl mezi skupinovým a individuálním pojištěním spočívá ve způsobu, jak pojištění získat. Zatímco na (většinou levnější) skupinové zdravotní pojištění („group health insurance“) mají nárok členové určité skupiny (např. zaměstnavatele, odborové organizace, zájmové samosprávy, vysoké školy apod.) či jejich rodinní příslušníci, individuální zdravotní pojištění je určeno převážně pro ty, kteří přístup ke skupinovému pojištění nemají, nebo jej nechtějí využít. Pojišťovny přes individuální trh nabízejí také mnoho druhů dodatkových připojištění, např. úhradu léků na recept, zubní ošetření, úrazové pojištění, pojištění dlouhodobé péče či pojištění pro případ dlouhodobé nemoci nahrazující ztrátu příjmů v důsledku dlouhodobé pracovní neschopnosti. Více než 90 % soukromých pojištěnců čerpá skupinové zdravotní pojištění, zejména pojištění zaměstnanecké.

Soukromé zdravotní pojištění je financováno výhradně z pojistného a právní vztah mezi zdravotním pojištěncem a zdravotní pojišťovnou se z velké míry podobá

klasickému pojistnému vztahu. Nicméně na rozdíl od pojištění nezdravotních, smlouva o zdravotním pojištění podléhá poměrně přísné regulaci co do obsahu pojistného plnění, použitých definic atd. Současně se uplatní i obecná ochrana spotřebitele, např. výklad neurčitých ustanovení smluv ve prospěch spotřebitele v souvislosti s problematikou adhezních smluv.

Veřejné či vládní zdravotní pojištění je financováno převážně z daní a mají na něj nárok různě znevýhodnění občané (finančně, zdravotně, věkově, rasově atd.). Pilíř veřejného zdravotního pojištění tvoří Medicare (program úhrad zdravotních služeb především za seniory), Medicaid (program pro sociálně slabé občany) a CHIP (program pro děti z nízkopříjmových rodin). Systém doplňuje vládou hrazená zdravotní péče pro americké indiány a válečné veterány. „Uniformovaní příslušníci" státních služeb (námořnictvo, vojáci, členové aktivní zálohy, jejich rodinní příslušníci atd.) spadají pod vojenské (armádní) zdravotnictví, které má dokonce i vlastní poskytovatele zdravotních služeb (vojenské nemocnice a centra). Vojenské či armádní zdravotnictví funguje nezávisle na civilním zdravotnictví a vyznačuje se velmi vysokou úrovní zdravotní péče. Výše uvedené veřejné zdravotní programy v různé míře zajišťuje federální vláda, a to buď sama nebo ve spolupráci se státními vládami. Jednotlivé státy mohou založit a financovat další veřejné zdravotní programy dle libosti. Příkladem je existence státních „risk-pools" nabízejících zdravotní pojištění občanům, které soukromé pojišťovny odmítají pojistit z důvodu jejich zdravotního stavu.

V první kapitole dále najdeme historii zdravotní péče a zdravotního pojištění ve Spojených státech, která má za cíl přiblížit čtenářům důvody, které vedly, a události, které přispěly, k nezavedení systému univerzálního zdravotního pojištění.

Druhá kapitola práce se věnuje právu zdravotní péče. Pojednání o jednotlivých institutech práva zdravotní péče předchází stručné shrnutí fungování právního systému Spojených států. Základ veškerého práva představuje Ústava Spojených států, která vymezuje hranice mezi federálním a státním právem a federální vládou a vládami jednotlivých států. Tento vztah je založen na principu „vyjmenovaných pravomocí" („enumerated powers"), podle kterého federální vláda disponuje pouze těmi pravomocemi, které jí Ústava taxativně svěřuje, a nemůže regulovat či zasahovat do oblastí, v kterých nebyla pověřena. Veškeré zbylé oblasti, tedy vše, co není taxativně určeno federální vládě, spadá do působnosti států. Bohužel, Ústava obsahuje místy

velmi široká vymezení pravomocí, která je nutné většinou složitě interpretovat, aby bylo hranice mezi federální a státní úpravou vůbec možno určit. Notoricky známý příklad představuje tzv. „klauzule obchodu“ („commerce clause“), podle které je federální vláda oprávněna regulovat obchod s cizinou, obchod mezi jednotlivými státy a obchod s americkými indiány. Americký ústavní soud tuto klauzuli v poslední době vykládá velmi extenzivně ve prospěch federální vlády, což se samozřejmě (a mnohdy oprávněně) nelíbí státům. Právě na základě rozšiřujícího výkladu tohoto ustanovení je federální vláda oprávněna právně regulovat zdravotní pojištění na federální úrovni. Nejdůležitější spor o rozsah pravomocí z poslední doby se týká přímo reformy zdravotní péče z roku 2010 (viz dále).

Sektor zdravotnictví je nejspíše nejvíce regulovaným sektorem americké ekonomiky. Tomu odpovídá i ohromné množství právních předpisů (federálních i státních) kolem zdravotní péče a zdravotního pojištění. O právní úpravu zdravotnictví se dělí federální vláda s vládou státní. Federální vláda opírá pravomoc o již zmíněnou klauzuli obchodu. Jak federální, tak státní vlády většinou delegují své pravomoci na ministerstva zdravotnictví a ostatní správní úřady fungující v okruhu zdravotnictví, které mohou dále vydávat podzákonné právní normy v mezích své působnosti a ukládat sankce za jejich porušení. Kombinace všemožných forem a pramenů práva, od různých subjektů a navíc různé právní síly vytváří opravdové právní bludiště. Přehlednosti nepomáhá ani to, že do práva zdravotní péče nepatří pouze regulace zdravotního pojištění, nýbrž veškeré vztahy mezi pacienty a lékaři, povinnosti poskytovatelů zdravotní péče, otázky mlčenlivosti, ochrany osobních údajů a přístupu k informacím ve zdravotnictví, problematika informovaného souhlasu, eutanazie, potratu, prohlášení za mrtvého, zanedbání povinné péče, podvody a zneužití zdravotní péče, pojistné smlouvy, či kartelové a antimonopolní právo poskytovatelů zdravotní péče aj. V této části práce se detailněji věnujeme zanedbání povinné péče a souvisejícím soudním sporům, podvodům a zneužitím zdravotní péče, právu na léčbu a odpovídající povinnosti poskytnout léčbu a v neposlední řadě základním principům kartelového a antimonopolního práva v oblasti zdravotnictví.

Třetí kapitola podrobněji pojednává o jednotlivých typech plánů zdravotního pojištění („health insurance plans“ nebo „health coverage plans“). Každý pojištěnec (soukromý i veřejný) si uzavřením pojistné smlouvy volí konkrétní typ plánu, který

nejlépe vyhovuje jeho potřebám a finančním možnostem. Plán zdravotního pojištění si lze představit jako pojistnou smlouvu týkající se zdravotního pojištění, kde jsou přesně vymezeny benefity (zdravotní služby), které jsou z pojištění hrazeny, a podmínky úhrady. Jednotlivé plány zdravotního pojištění se liší v různých atributech, např. výčtu zdravotních služeb, které se proplácejí, ve výši spoluúčasti, v limitech pro plnění apod. Obecně však tyto plány existují ve čtyřech základních typech, které můžeme vždy zařadit do jedné z následujících dvou skupin.

První skupinu tvoří tzv. fee-for-service plány, neboli plány proplácející poskytnutou zdravotní péči na základě vystavení účtu za každý jednotlivý individuální zdravotní výkon či službu. Druhou skupinu pak značíme jako tzv. managed care, neboli řízenou péči. Fee-for-service plány se objevily současně se vznikem zdravotního pojištění, řízená péče se naopak zrodila následně jako výsledek snahy redukovat náklady zdravotní péče až v 70. až 80. letech 20. století. Základní rozdíl mezi fee-for-service a řízenou péčí spočívá v možnosti zvolit si poskytovatele zdravotní péče. Zatímco fee-for-service plány pojištěnce ve výběru nijak neomezují, plány v systému řízené péče tento výběr limitují, za to ale jako kompenzaci nabízejí nižší cenu. Další odlišnosti najdeme v mechanismu placení za poskytnuté služby a ve výši spoluúčasti.

Princip fee-for-service plánů si nejlépe vysvětlíme na příkladu. Pojištěnec vlastnící zdravotní pojištění na bázi fee-for-service si zajde na rentgenové vyšetření a poté konzultuje výsledek s lékařem. Nemocnice vystaví pojišťovně zvlášť účet za rentgenové vyšetření a zvlášť účet za konzultaci lékaře. Pojišťovna poté po ověření údajů nemocnici zaplatí vyfakturované náklady za rentgenové vyšetření a vyfakturované náklady za konzultaci lékaře. Pojišťovna však obvykle začne hradit zdravotní péči až poté, co pojištěnec překročí limit pro úhradu nákladů z vlastních zdrojů. Ani po překročení limitu nebude náhrada nákladů pojištěnce fee-for-service plánu stoprocentní, nýbrž zhruba 80 %. Zbylých 20 % musí zaplatit pojištěnec přímo poskytovateli zdravotní péče (nemocnici, lékaři).

Řízená péče funguje poněkud komplikovaněji. Primárně pod pojmem řízená péče rozumíme několik podtypů plánů zdravotních pojištění, které se od sebe někdy velmi výrazně liší (HMO, PPO, POS). Někdy ale pojem řízená péče označuje přímo subjekty poskytující zdravotní péči na bázi řízené péče. Všechny plány v řízené péči mají společné to, že se snaží kontrolovat náklady a kvalitu zdravotní péče skrze

koordinaci poskytnutých zdravotních služeb. Entity fungující na bázi řízené péče (většinou pojišťovny) vytvářejí sítě poskytovatelů zdravotních služeb (skrze pracovní smlouvy, dohody o spolupráci atd.), kteří poté poskytují zdravotní péči a služby za diskontní ceny svým členům (pojištěncům plánů řízené péče). Povinnosti poskytovatelů zdravotní péče se odvíjí dle typu řízené péče. Někteří mohou svoje služby poskytovat i nečlenům, jiní ne; někteří mohou doporučit pacientům lékaře mimo síť, jiní se pacientům nemohou ani zmínit o léčebné alternativě, která není hrazena z pojištění. Poslední případ se označuje jako tzv. „gag clause“ (roubíková klauzule), a je zakázán státním právem, stejně jako mnoho dalších nekalých jednání pojišťoven. Pojišťovny praktikující řízenou péči totiž s cílem snížit náklady v minulosti velmi limitovaly práva a léčebné možnosti pacientů, a tak státy přistoupily téměř jednotně k hromadnému zákazu nejčastějších omezujících a nečestných praktik. Řízená péče ale opakovaně prokázala, že dobrou koordinací zdravotních služeb je možné trvale snížit náklady na zdravotní péči (a tedy i cenu zdravotního pojištění), a proto v současnosti plány řízené péče převažují nad tradičními fee-for-service plány.

Novým konceptem v oblasti řízení zdravotní péče je tzv. „consumer driven health care“ (zdravotní péče řízená spotřebitelem) neboli CDHC. CDHC je také zaměřena na snižování nákladů zdravotní péče, nicméně na rozdíl od řízené péče přesouvá břemeno managementu zdravotní péče včetně snahy snížit náklady na pojištěnce. CDHC plány se používají ve spojení s plány s vysokou spoluúčastí (tzv. „high deductible health plans“) nebo tzv. katastrofickými plány. CDHC plány totiž umožňují použít specifických platebních metod k placení rutinní, levné zdravotní péče, zatímco zdravotní pojištění s vysokou spoluúčastí pokrývá případnou nákladnou zdravotní službu.

Specifickými platebními metodami rozumíme většinou různé daňově zvýhodněné spořící účty. Pojištěnec si založí CDHC spořící účet, na který vloží peněžní prostředky přibližně ve výši spoluúčasti svého zdravotního pojištění. Veškeré prostředky na účtu jsou osvobozeny od daně (včetně úroků), pokud jsou použity pouze na „koupi“ zdravotních služeb. Tím, že si pojištěnec platí rutinní zdravotní péči z vlastních prostředků, se logicky snaží co nejvíce ušetřit a získat nejlepší poměr „cena - výkon“. Zdravotní péče se tak zbytečně neplýtvá a navíc motivuje poskytovatele ke zlepšování kvality péče. Na nekvalitní zdravotní služby pojištěnci vlastní peníze

nevynaloží. Pojištění poté kryje kvalifikovanou, specializovanou a finančně náročnější zdravotní péči, např. složité operace či dlouhodobý pobyt v nemocnici. Kritici konceptu se obávali, že lidé ve snaze ušetřit nebudou zdravotní péči čerpat vůbec, např. přestanou chodit na preventivní prohlídky. Opak se ukázal pravdou a zavedení CDHC tak potvrdilo, že pojištěnci jsou schopni činit kvalifikovaná informovaná rozhodnutí o své zdravotní péči sami a není mnohdy potřeba, aby stát intervenoval a reguloval veškeré aspekty zdravotní péče centrálně. CDHC na počátku roku 2010 využívalo asi 10 milionů lidí. O zavedení CDHC by se dalo uvažovat i v České republice v souvislosti s placením „regulačních poplatků".

Čtvrtá a pátá část diplomové práce se věnují podrobněji jednotlivým druhům zdravotního pojištění, včetně jejich právní regulace. Čtvrtá kapitola pokrývá soukromé zdravotní pojištění, pátá pak veřejné zdravotní pojištění.

Soukromé zdravotní pojištění je hlavní zdroj pojištění pro většinu Američanů. Jak již bylo řečeno výše, rozeznáváme skupinové zdravotní pojištění a individuální zdravotní pojištění. Soukromé zdravotní pojištění obecně je založeno na smluvním vztahu, kdy se pojistník zavazuje platit pojišťovně pravidelné pojistné („premiums") a pojišťovna se na oplátku zavazuje hradit vzniklé výdaje za zdravotní péči pojištěnce. Tento vztah je problematický z několika důvodů, a to nejen ve zdravotním pojištění, ale v pojištění obecně. Především jeho životaschopnost zcela závisí na finanční solventnosti pojistitele. Pojištěnec se musí spolehnout na to, že pojistitel bude řádně platit výdaje na zdravotní péči poskytovatelům zdravotní péče a nebude provádět nečestné a nekalé obchodní praktiky. Pojistnou smlouvu (a jí odpovídající plán zdravotního pojištění) navíc můžeme označit jako tzv. adhezní kontrakt, který pojistitel víceméně standardizuje a pojištěnec tak většinou nemá možnost domáhat se změn v podmínkách smluvního vztahu. Na druhé straně, adhezní povaha pojistné smlouvy zaručuje pojištěncům příznivější soudní ochranu v případných sporech. Soudy vykládají ustanovení smlouvy právě s přihlédnutím k faktu, že pojištěncům (spotřebitelům) nebylo umožněno prosadit změny či doplnění v procesu přípravy smlouvy, a proto se např. ambivalentní ustanovení takové smlouvy interpretují zásadně ve prospěch pojištěnců. Samozřejmě se současně aplikuje i obecné právo ochrany spotřebitelů. Pojišťovny však nemají zcela volnou ruku v přípravě pojistných smluv, jak by se mohlo zdát. Plány soukromých zdravotních pojišťoven podléhají přísné regulaci, a to jak

federální, tak státní. Za určitých podmínek dokonce veřejné zdravotní programy kupují pro své pojištěnce zdravotní pojištění u soukromých pojišťoven, proto musí plány pojišťoven splňovat spoustu požadavků, pokud si přejí spolupráci s veřejným sektorem.

Specifické problémy související se smluvním vztahem pojištěnce a pojistitele řeší i pojišťovny. Klasické fenomény pojišťovnictví, se kterými se pojišťovny musí vypořádat, jsou např. morální hazard, asymetrie informací či problematika nepříznivého výběru.

Přestože soukromé zdravotní pojištění má velmi blízko k ostatním druhům komerčního pojištění (např. havarijní pojištění), trh zdravotního pojištění ve Spojených státech funguje zcela jinak než jakýkoliv jiný trh zboží či služeb nabízející své produkty (včetně komerčního pojištění) spotřebitelům. Na standardním trhu zboží a služeb se totiž nabízející strana (prodejci) snaží vygenerovat co nejvyšší poptávku (zákazníky), prodat co nejvíce výrobků (produktů) a tak dosáhnout maximálního zisku. Trh zdravotního pojištění je naopak velmi vybíravý. Pojišťovny nelákají na své produkty (zdravotní pojištění) všechny potenciální zákazníky, naopak existuje jakási „předselekce“ zákazníků a zdravotní pojištění (resp. jednotlivé plány zdravotního pojištění) je nabízeno pouze vybraným klientům, u kterých je vysoká pravděpodobnost, že budou v budoucnu potřebovat pouze finančně nenáročnou základní a rutinní zdravotní péči. Ostatním klientům je možnost uzavřít smlouvu na zdravotní pojištění odepřena nebo nabídnuta za mnohem vyšší cenu ve srovnání s ostatními pojištěnci. Ve skutečnosti právní předpisy neumožňují pojišťovnám takto jednoduše odmítat klienty, nicméně zjednodušeně trh podobně opravdu funguje. Jedním z důvodů je skutečnost, že státní a federální legislativa zakázala pojišťovnám stanovit výši (cenu) pojistného v závislosti na zdravotním stavu svých klientů. Jsou - li tedy pojišťovny nuceny nabízet zdravotní pojištění všem klientům za stejnou cenu, bez ohledu na jejich různou „rizikovost“, nelze se divit, že reagují odmítáním klientů, u nichž by prostě vybrané pojistné nepokrylo náklady. Odmítání uzavření pojistné smlouvy s lidmi, kteří již mají existující zdravotní problém v době uzavírání pojistné smlouvy, patří mezi hlavní problémy soukromého zdravotního pojištění. Nová právní úprava spojená s reformou zdravotnictví ale postupně eliminuje tuto praxi pojišťoven, a v roce 2014 by již podobné praktiky měly být zcela zakázány.

Problematika soukromého pojištění je však mnohem komplexnější než je zde popsáno, diplomová práce se zabývá soukromým pojištěním mnohem podrobněji a komplexněji. Soukromé zdravotní pojištění přináší i mnohé výhody svým pojištěncům, zejména pokud jde o zdravotní pojištění zaměstnanecké. Pojištěnci zaměstnaneckého zdravotního pojištění těží ze spousty výhod, které takové pojištění nabízí. Zejména získávají za relativně nízké ceny (v důsledku úspor z rozsahu) pojištění velice komplexní plány zdravotního pojištění zahrnující např. welness aktivity (sauna, posilovna) či plné hrazení léků na recept. Individuální zdravotní pojištění bývá dražší, na druhé straně umožňuje zcela individuální přístup k potřebám klientů na rozdíl od zaměstnaneckého pojištění. Navíc většinou obsahuje i různá připojištění, která se běžně hradí samostatně, např. pojištění pro případ dlouhodobé pracovní neschopnosti. Zaměstnanci mají přístup k omezené nabídce plánů zdravotního pojištění, výjimkou není, když zaměstnavatel předloží pouze jeden typ.

Co se týče právní regulace soukromého pojištění, dělí se o pravomoc, jak již bylo několikrát zmíněno, státy i federální vláda. Kromě velkého množství zákonů upravujících jednotlivé aspekty soukromého pojištění přijímají obě vlády tzv. mandáty, které vymezují minimální rozsah zdravotní péče, jež musí plány zdravotního pojištění povinně hradit. V současnosti existuje více než dva tisíce takovýchto mandátů používaných současně. Mandáty vyžadují, aby smlouvy o zdravotním pojištění (plány zdravotního pojištění) přispívaly na úhradu např. služeb chiropraktiků, porodních asistentek či rehabilitačních sester, mamogramů, dětské zdravotní péče, akupunktury atd. Každý stát uplatňuje jiné mandáty, požadavky na pojistné smlouvy se tedy mezi jednotlivými státy liší. Federální vláda ale také přijímá mandáty, v tomto případě s celonárodní působností, jejichž smyslem je právě koordinovat státní legislativu mandátů a zmírnit rozdíly v obsahu jednotlivých typů plánů mezi státy. Všechny plány zdravotního pojištění musí tedy splňovat požadavky federálních mandátů, a současně vyhovět případným státním mandátům platným v místě uvedení plánu zdravotního pojištění na trh. Federální mandátem je určena např. minimálně 48 hodinová plně hrazená hospitalizace související se standardním porodem. Jakmile by ale šlo o porod císařským řezem, všechny plány zdravotního pojištění musí uhradit minimálně 96 hodin pobytu v nemocnici včetně v té době poskytnutých zdravotních služeb.

Ačkoliv mandáty výrazně přispívají ke zlepšení kvality nabízených plánů zdravotního pojištění, jsou jedním z důvodů, proč ceny zdravotního pojištění ve Spojených státech rostou. Mandát začne vyžadovat zahrnutí více „benefitů“ (jako „benefit“ se v této souvislosti označuje zdravotní služba, která je hrazena nebo na kterou je přispíváno velkou měrou ze zdravotní pojistky) do plánů zdravotního pojištění a pojišťovny přistoupí k hromadnému zdražení pojistného, jelikož dodatečné zdravotní služby je nutné z něčeho zaplatit. Legislativa zakazuje diverzifikovat ceny pojistného dle typů pojištěnců, vzrostou tedy ceny všech plánů zdravotního pojištění.

Do soukromého zdravotního pojištění patří kromě zaměstnaneckého a individuálního zdravotního pojištění ještě pojištění federálních zaměstnanců (včetně členů Kongresu). Zaměstnanci federální vlády si vybírají zdravotní pojištění z obrovského množství různých plánů (přes 250), ale na rozdíl od klasického zaměstnaneckého pojištění si hradí až 25 % z ceny pojistného sami. Ostatní, nefederální zaměstnanci naopak obdrží průměrně od zaměstnavatele příspěvek na pojistné ve výši 83 % z ceny pojistného, a více než 18 % zaměstnanců dostane zdravotní pojištění od zaměstnavatele zcela zdarma. Právní regulace se vedle individuálního pojištění zaměřuje na zaměstnanecké pojištění, jelikož až 90 % všech klientů soukromých pojišťoven uzavírá zdravotní pojištění skupinové přes zaměstnavatele. Zaměstnavatelé nemají zatím povinnost zdravotní pojištění poskytovat, ale díky daňovému zvýhodnění převážná většina velkých zaměstnavatelů (s více než 50 zaměstnanci) zdravotní benefity poskytuje. Zaměstnavatel, který se rozhodne zajistit svým zaměstnancům zdravotní pojištění, podléhá enormnímu množství federálních i státních právních předpisů, jejichž stručný výčet s krátkými popisky je v diplomové práci obsažen. Pokud však zaměstnavatel zvolí samopojištění místo koupě plánu zdravotního pojištění od soukromé pojišťovny, federální úprava se na něj ve většině případů nebude vztahovat.

Pátá kapitola pojednává o jednotlivých druzích veřejného zdravotního pojištění. Veřejné zdravotní pojištění poskytuje či hradí zdravotní péči seniorům, jednotlivcům a domácnostem s nízkými příjmy okolo hranice chudoby (hranice chudoby je federálně stanovená hranice příjmů pro jednotlivce i rodiny, od které se odvíjí mj. příspěvky státní sociální podpory), určitým dětem, lidem se specifickými zdravotními problémy (např. selhání ledvin), postiženým, ale také válečným veteránům či členům uniformovaných

služeb. Veřejné zdravotní pojištění se skládá z několika subsystémů (programů) a zajišťuje zdravotní péči přibližně jedné třetině obyvatel Spojených států.

Medicare označuje program zdravotní péče pro občany starší 65ti let, občany s určitým hendikepem a jedince s trvalým selháním ledvin. Medicare je výlučně federální program, na rozdíl od Medicaid programu (viz dále). Administrativu Medicare vykonává Ministerstvo zdravotnictví a zdravotní péče je financována převážně z daní. Medicare přispívá na úhradu nákladů spojených se zdravotní péčí výše uvedeným skupinám osob. Ačkoliv jde o veřejný program, vyžaduje poměrně vysokou spoluúčast od pojištěnců. Základní Medicare pojištění, tzv. Medicare část A (nemocniční pojištění hradící náklady spojené s pobytem v nemocnici včetně poskytnuté zdravotní péče) je „zdarma“ v tom smyslu, že pojištěnci neplatí pojistné. Během svého života totiž většinou odváděli daně, které toto pojištění financují. Nicméně aby Medicare počal s úhradou nákladů, musí pojištěnec nejprve zaplatit určitou sumu za výdaje spojené se zdravotní péčí ze svých prostředků. V roce 2010 činí tato částka („deductible“) 1100 dolarů/rok. Za ostatní pojištění v rámci Medicare (pojištění zdravotních služeb poskytovaných lékaři a pojištění úhrady léků na recept) je již nutné zaplatit pojistné. I přes vysokou úroveň spolufinancování pojištěnci se výdaje na Medicare vyšplhaly na 484 miliard dolarů v roce 2010.

Druhým nejznámějším americkým veřejným programem pro krytí výdajů zdravotní péče je Medicaid. Medicaid je určen domácnostem s nízkými příjmy, pokud zároveň spadají do některé z kvalifikačních skupin, kterým Medicaid hradí náklady zdravotní péče. Pouhé nízké příjmy nepostačují k zařazení do programu, pro čerpání Medicare se musí přidat ještě další sociální skutečnost, která dále znevýhodňuje žadatele o program, např. těhotenství, slepota či jiný hendikep, vysoký věk. Účast na Medicare nevylučuje čerpání Medicaid. Naopak, senioři s nízkými příjmy, kteří mají problémy s placením vysokých částek spoluúčasti v rámci Medicare, mohou využít Medicaid, který spoluúčast uhradí. Medicaid řídí federální vláda ve spolupráci se státními vládami. Těžiště programu je na státní úrovni (v rámci federální vládou vymezených hranic si každý stát upravuje kritéria pro účast na Medicaid autonomně), federální vláda se ale podílí na financování programu. I pojištěnci Medicaid si musí připlácet na zdravotní služby, avšak vzhledem k tomu, že jde o nízkopříjmové jedince, je tato spoluúčast výrazně omezená.

Dětské zdravotní pojištění na veřejné úrovni zajišťuje CHIP. CHIP, stejně jako Medicaid, funguje na základě spolupráce federální vlády s vládami státními. CHIP vznikl až v roce 1997 (Medicare i Medicaid byly založeny již v 60. letech 20. století), původně na omezenou dobu deseti let, v roce 2007 byl však program prodloužen do roku 2009 a v roce 2009 znovu, tentokrát až do roku 2013. Podobně jako u Medicaid si státy sami nastavují kritéria pro účast v programu. Federální vláda pouze vymezuje meze, v kterých se státy mohou pohybovat. Obecně platí, že CHIP hradí zdravotní péči dětem z rodin s příjmy do 200 % hranice chudoby, ale některé státy rozšířili pojištění až do výše 300 % hranice chudoby. CHIP zajišťuje zdravotní péči, včetně zubního lékařství, také těhotným ženám.

K dalším programům veřejné zdravotní péče patří MHS, TRICARE (systémy vojenské zdravotní péče), program zdravotní péče pro válečné veterány a péče pro americké indiány. Tyto programy nejen zajišťují úhradu zdravotní péče, ale přímo zdravotní péči poskytují skrze vlastní nemocnice, lékaře a jiná zdravotnická centra, na rozdíl od Medicaid, Medicare a CHIP, kteří pouze proplácejí výdaje za zdravotní služby soukromých poskytovatelů zdravotní péče poskytnuté jejich pojištěncům.

Americké vojenské zdravotnictví (programy MHS a TRICARE) je na špičkové úrovni. Poskytuje převážně bezplatné zdravotní služby členům uniformovaných sborů v aktivní službě (např. námořnictvo, armáda, letectvo) a jejich rodinným příslušníkům, pokud to dovolí kapacita, a dále za malý poplatek zdravotní péči např. členům Kongresu či prezidentu USA. Členové Kongresu ale spadají primárně pod zdravotní pojištění poskytované federálním zaměstnancům.

Po propuštění z aktivní služby využívají vojáci (veteráni) služby zdravotní péče v rámci Ministerstva pro záležitosti veteránů. Péče pro válečné veterány se kromě své dobré kvality vyznačuje i vysokou mírou elektronizace zdravotní péče (např. zásadně používá pouze elektronické zdravotnické záznamy). Více než 1400 zdravotních center však ani zdaleka nepokryje poptávku po zdravotních službách, proto jsou vytvářeny pořadníky pro přístup ke zdravotní péči. Prioritu mají váleční veteráni se zraněními nebo nemocemi souvisejícími s výkonem služby. Nárok na zdravotní péči pro veterány mají vysloužilci přibližně po 2 letech strávených v aktivní službě.

Poslední kapitola práce (reforma zdravotní péče 2010) shrnuje nejdůležitější změny související s nedávným přijetím reformy zdravotnictví. Reforma zdravotní péče

(resp. Zákon o ochraně pacientů a cenově dostupné zdravotní péči z roku 2010) byla podepsána prezidentem USA Barrackem Obamou 23. března 2010. Jedná se o jeden z nejdůležitějších legislativních aktů v historii Spojených států, protože kompletně reorganizuje národní systém zdravotní péče a slibuje milionům Američanů přístup k cenově výhodnému zdravotnímu pojištění. Plné účinnosti zákon nabude v roce 2014. Reforma je dílem Demokratů, ačkoliv i Republikáni předložili konkurenční koncepty systémových změn ve zdravotní péči.

Téměř okamžitě po podpisu zákona prezidentem Obamou podalo celkem 21 států žaloby k obvodním federálním soudům pro údajnou protiústavnost zákona. Zákon je napadán z několika důvodu, nicméně hlavní příčinu protiústavnosti státy spatřují v tom, že zákon vyžaduje, aby všichni občané až na pár výjimek vlastnili zdravotní pojištění. V případě, že si zdravotní pojištění neopatří, uplatní se finanční sankce. Dle států nemá federální vláda pravomoc v podstatě nutit občany uzavřít smlouvu se soukromým subjektem a koupit si „produkt“, a už vůbec ne občany penalizovat za tuto „ekonomickou neaktivitu“, tj. za to, že se rozhodnou nekoupit si určitý produkt (ač je to zdravotní pojištění). Americké ministerstvo spravedlnosti však oponuje, že rozhodnutí neobstarat si zdravotní pojištění není nekonání, nýbrž aktivní konání spočívající v odhodlání platit si zdravotní péči jen z vlastních zdrojů. Vzhledem k tomu, že většina Američanů si nemůže dovolit hradit veškeré náklady zdravotní péče bez pojištění, toto rozhodnutí nepojistit se akorát působí přesun nákladů zdravotní péče za tyto občany na nemocnice, daňové poplatníky a nakonec na všechny zdravotní pojištěnce, kteří si pojištění řádně platí. Jednotlivé soudní spory se pravděpodobně skrze opravné prostředky dostanou až k Nejvyššímu soudu, proto se dá očekávat, že finální rozhodnutí o ústavnosti/neústavnosti reformy spatří světlo světa až cca v roce 2013.

Kromě již zmíněné povinnosti Američanů pořídit si zdravotní pojištění reforma mimo jiné zakazuje některé praktiky pojišťoven (např. již zmíněné odmítání pojištění či diskriminaci klientů s existujícím zdravotním problémem), zakládá Burzy cenově dostupného zdravotního pojištění či zvyšuje kapacitu veřejných zdravotních pojištění. Hlavním cílem reformy je snížení nákladů na zdravotní péči, a to nejen cen zdravotního pojištění, nýbrž nákladů jednotlivých zdravotních služeb celkově skrze vytvoření efektivnějšího systému poskytování zdravotní péče.

Odhaduje se, že reformní opatření zatíží rozpočet cca 938 miliardami dolarů, nicméně výsledné snížení nákladů by mělo snížit schodek rozpočtu o více než 138 miliard během prvních deseti let od účinnosti opatření a o další jeden bilion během následujících deseti let. Náklady reformy ponesou daňoví poplatníci. Některé druhy daní byly zvýšeny a dokonce došlo k zavedení zcela nové, 10% spotřební daně z opalování v soláriích.

Původní zákon o ochraně pacientů a cenově dostupné zdravotní péči byl již novelizován zákonem o sladění zdravotní péče a vzdělání, který např. snížil pokutu za absenci obligatorního zdravotního pojištění z původních 750 dolarů na 695 dolarů. Jednotlivá ustanovení reformních zákonů budou nabývat účinnosti postupně od teď až do roku 2014, kdy by dle slibů vlády měli všichni Američané vlastnit zdravotní pojištění.

Nejdůležitější změny platné již od roku 2010 zahrnují: zákaz pojišťoven odmítnout poskytnutí zdravotního pojištění dětem do 19ti let na základě zdravotního stavu; zákaz pojišťoven stanovovat limity na krytí výdajů na základní zdravotní služby (např. pobyt v nemocnici); zavedení daňových bonusů pro zaměstnavatele s méně než 50ti zaměstnanci, kteří svým zaměstnancům poskytují zdravotní pojištění; zavedení slev na léky na recept pro pojištěnce Medicare; či uvolnění dodatečných federálních fondů na financování Medicaid.

Dále, od roku 2011 pojišťovny např. musí použít minimálně 80 % z vybraného pojistného na zdravotní služby nebo poskytnout svým klientům slevu na pojistném.

V roce 2012 by se měl zavést plně elektronický systém zdravotních záznamů, od kterého se očekává převážně zvýšení bezpečnosti pacientů a snížení nákladů na administrativu.

V roce 2013 dojde mimo jiné k navýšení federálních příspěvků na rozšíření programu Medicaid.

V roce 2014 nastane plná účinnost většiny opatření. Pojišťovny již nebudou moci diskriminovat pacienty na základě existujícího zdravotního stavu, ani jim odmítat pojištění. Ani nebude povoleno vyžadovat vyšší pojistné na těchto klientech. Současně nebude možné stanovovat rozdílné pojistné pro muže a ženy. Dále bude pojišťovnám zakázáno limitovat výši plnění za zdravotní služby. Američané s příjmy do 400 % hranice chudoby obdrží příspěvek na pořízení zdravotního pojištění formou daňového

zvýhodnění. Medicaid sjednotí podmínky pro účast v programu a bude hradit zdravotní péči všem občanům s příjmy pod 133 % hranice chudoby. V neposlední řadě nabude účinnosti výše zmíněný tzv. individuální mandát, a po všech občanech bude vyžadováno vlastnictví zdravotního pojištění. Plán zdravotního pojištění nemusí mít občané, kteří si ani přes všemožné příspěvky a daňová zvýhodnění nemohou zdravotní pojištění dovolit a dále ti, jež nesouhlasí s konceptem zdravotního pojištění z náboženských důvodů. Otázkou je, zdali zvláště druhá výjimka nebude zneužívána. Cenově dostupné pojištění v minimálně čtyřech variantách bude možno zakoupit na Burzách zdravotního pojištění. Výhodné zdravotní pojištění si na oddělených Burzách budou moci pořídit jak jednotlivci, tak zaměstnavatelé do 100 zaměstnanců a dále členové Kongresu. Počínaje rokem 2014 totiž zaměstnavatelé s více jak 50 zaměstnanci budou povinni poskytovat zdravotní pojištění svým zaměstnancům pod hrozbou sankce ve výši 2000 dolarů za každého zaměstnance. Právě v koncept Burz zdravotního pojištění jsou vkládány obrovské naděje, zejména s ohledem na snížení počtu nepojištěných občanů.

Nezbývá než počkat minimálně do roku 2014, než zhodnotíme, do jaké míry reforma splnila své sliby. I když mnoho ustanovení působí relativně protichůdně (např. snížení nákladů jako hlavní cíl reformy v kombinaci s rozšiřováním počtu obyvatel způsobilých pro účast ve veřejném pojištění), není vyloučeno, že se opravdu zaslouží o zlepšení stavu amerického zdravotního systému.

Ve svém závěru práce kromě obligatorního shrnutí a zhodnocení systému zdravotní péče v širším konceptu krátce představuje i možnosti implementace několika institutů amerického systému zdravotní péče na zdravotnictví v České republice.

ABSTRACT

Title: Health Care in the United States of America

The purpose of my thesis is to analyze the operation of the health care system in the United States of America. The thesis focuses in particular on health care regulation and health insurance.

The primary reason for my research is the lack of literature on similar topic in the Czech Republic, which would describe comprehensibly how the system works with respect to regulation. There are various resources on the individual issues of the U.S. health care, but I found it very hard to encounter cumulative information about the whole system, for example for the purposes of understanding the U.S. health care reform, which was brought up several times in the Czech press. Also, with the upcoming reform of public finances in the Czech Republic, health care included, I feel it is necessary to acknowledge how different health care systems work to learn what possible options are there for the improvement of the Czech Republic health care.

The thesis is composed of six chapters, each of them dealing with different aspects and elements of the U.S. health care system.

The first chapter provides general background for health care and health insurance in the U.S. along with the historical excurse to introduce the basic principles upon which the system has been operating.

The second chapter concerns health care law and is divided into two subchapters. While the first one outlines the U.S. law system, the second one discusses what health care law actually is and mentions several health care law issues, such as malpractice or health insurance fraud.

The third, fourth and fifth chapters focus on health insurance market and its regulation. The third chapter describes main types of health insurance plans the Americans can come across and purchase, from traditional fee-for-service health plans to progressive consumer driven health care options. The fourth chapter discusses private health insurance, especially the nature of private health insurance relationship and the ways how to obtain private health insurance plan. The fifth chapter looks at various

public health insurance alternatives, including specific health care systems for military personnel or Native Americans.

The final, sixth chapter, gives a general idea what the 2010 health care reform is all about and what it means for the U.S. health care system.

The thesis should provide overview of how the U.S. health care system works as of the August 2010 (at the edge of effectiveness of health care reform) and enable the readers to form opinions on possible advantages and disadvantages of the system as well as to evaluate the effectiveness and fairness of the system.

KEYWORDS

Health Care, Health Insurance, Health Care Reform

zdravotní péče, zdravotní pojištění, reforma zdravotnictví