

Chapter 1

The continuous rise in overall spending on U.S. health care over the past 10 years maintains the focus on containing costs while improving patient care outcomes. Medicare expenditures for hospital Part A and medical Part B services have risen year after year, with some double-digit growth. Pharmaceutical expenditures have also risen with double-digit growth when measured year to year.

Staffing shortages and workforce job commitment are establishing new areas of concern for health services managers. As a result, pressure on health care managers remains to consistently provide more affordable health care with the same or better outcomes from patient care. These issues will affect the implementation of new Part D medication coverage benefits as well as programs that could help beneficiaries, such as medication therapy management (MTM). Pharmacists will need to identify key internal and external stakeholders of reimbursement in order for a MTM services program to succeed.

Issues Surrounding Health Care Reimbursement

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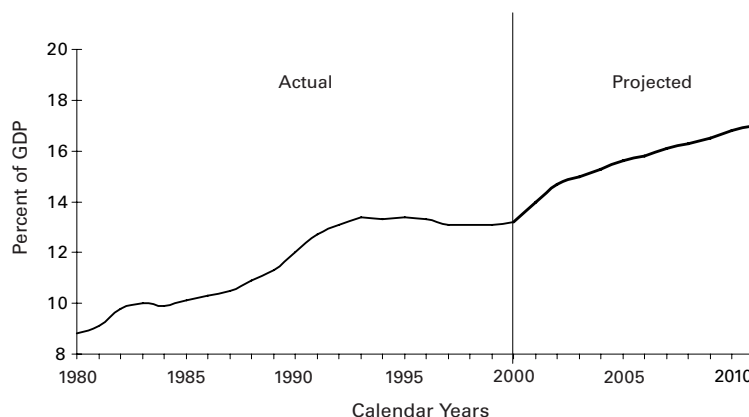
State of U.S. Economy

With the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) [Public Law 108-173], the focus on medications and pharmaceutically related services has been renewed. MMA creates a new Part D coverage for medications that had not been traditionally covered as part of the mainstream Medicare benefit. Now an expanded number of recipients may be eligible for coverage of medications that some say will bankrupt the Medicare program or at least force more draconian restrictions or cutbacks of services to elderly beneficiaries.

From selected national economic indicators reported by the Centers for Medicaid and Medicare Services (CMS), annual percent change in gross domestic product (GDP) has been 3.2–4% between 2000 and 2004 (**Figure 1-1**). Medical care costs have increased 4.1–4.7% during that same period, while all items less medical care were 2.8–3.4%. **Figure 1-2** shows additional select economic indicators for GDP dollars and medical

FIGURE 1-1
National Health Expenditures as a Share
of Gross Domestic Product (GDP)

Between 2001 and 2011, health spending is projected to grow 2.5 percent per year faster than GDP, so that by 2011 it will constitute 17 percent of GDP.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

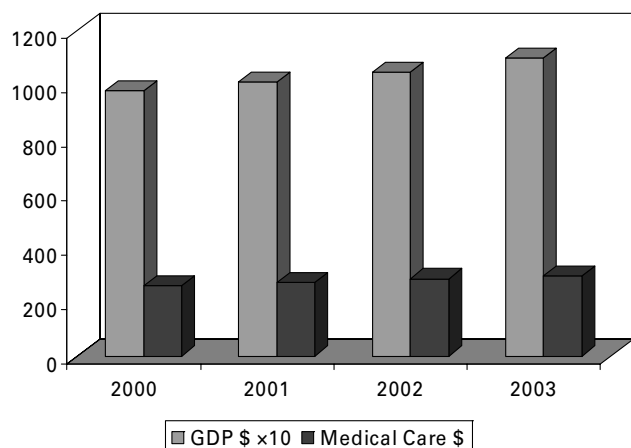
care prices versus a base period of 1982–1984. **Figure 1-3** shows the planned U.S. government spending for 2005 and illustrates the prominence of health care spending across the federal government budget. **Figure 1-4** illustrates total public spending for 2002 and shows where health care dollars were spent by major category; **Figure 1-5** shows where the nation's health dollars were spent in 2002.

The United States is not alone in its vulnerability to the total cost of caring for seniors. The Center for Strategic and International Studies regularly ranks the financial vulnerability of developed countries to aging. While the United States is among the best, Italy is among the worst due to its rapidly aging workforce and a system of generous benefits.¹

Employer Pushback

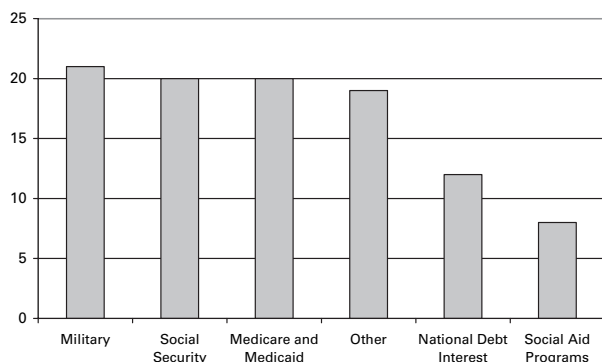
Increasingly, employers have been looking to health plans and pharmaceutical benefit managers to control the cost of health care benefit plans. In addition, employees (as consumers) have increasingly taken more control over benefit spending and pursued healthier behaviors or shared risk programs. Many private sector initiatives have emerged, along with changes in state or federal health coverage programs, that used similar strategies to better manage their expenditures.

FIGURE 1-2
National Economic Indicators



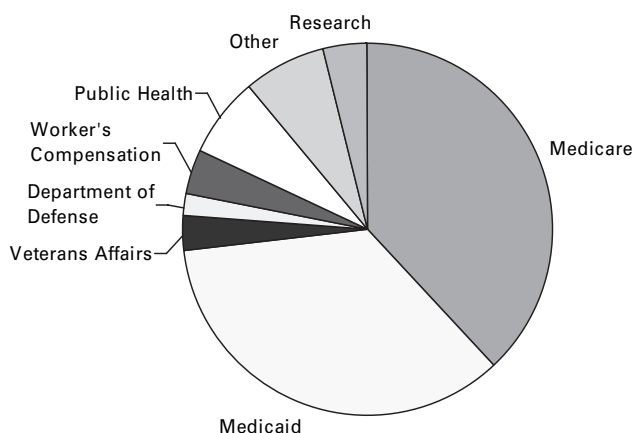
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

FIGURE 1-3
U.S. Government Spending
for Fiscal Year 2005



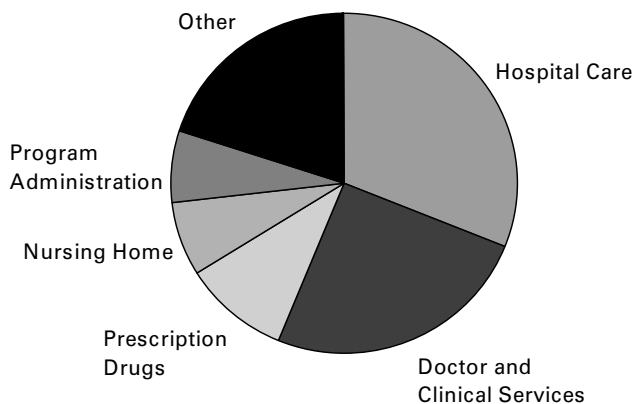
Source: Parade Magazine: Where does your money go? April 10, 2005, p. 4.

FIGURE 1-4
Total Public Spending, 2002



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

FIGURE 1-5
Nation's Health Dollar



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Traditionally, employers have tried preventing the involvement of the federal government in the private market through lobbying or grassroots efforts. However, in the debate leading to the passage of the MMA, employers welcomed an expanded role by the government since it could reduce their cost burden for retiree health benefits. It is not unusual for a large, self-insured employer to have 2–3 retirees per active employee.

While Medicare typically starts coverage at age 64½, the downsizing and rightsizing actions by employers over the past 20 years as well as longer lifespans have increased the overall employer retiree population. Moreover, aggressive employer reorganizations have resulted in attractive severance packages, with health care benefits, to include employees as young as 40 years old. In fact, while Medicare-eligible populations constitute the largest segment of retirees, it is the so-called “younger” retirees that are the second largest segment and key group for emerging cost-control efforts. As a result, efforts to eliminate, restrict, or change retiree health benefits continue to grow among employers.

An example of this dilemma in the lay press has been General Motors. Promises made to retirees have become so expensive as to threaten the U.S. economy. The imbalance in retiree obligations have placed GMs’ costs out of line with its ability to pay given the worldwide competition it finds itself in today.²

Patient Cost Sharing

In addition to the retiree health care cost burden, employers have remained concerned about the continual growth in health care after the spend dampening impact of managed care in the 1990s. Increases in year-to-year cost growth trends in health care have returned since 2003. As a result, the institution of tiered benefit coverage plans for medications, higher differential co-payments, higher deductibles, and growing use of other employee cost-sharing methods have increased over the past few years.

Those changes, along with the emergence of consumer-directed health plans (CDHP), has stimulated consumer re-engagement in health care decision making as well as cost. In fact, one of the fastest growing areas among health care expenditure payers is through the out-of-pocket costs paid for by consumers.³ The MMA will serve to only fuel the growth of consumers in health care plan decisions and spending through employer-sponsored Health Retirement Accounts (HRAs) or consumer-owned Health Savings Accounts (HSAs).

Escalating Costs Associated with New Technology

The U.S. health care system as the envy of the world also results in a burdensome cost—the cost of innova-

tion. The market-based, entrepreneurial U.S. health care system continues to improve processes, medication, and other therapies along with better diagnostic or treatment technologies that produce better outcomes. This technological improvement also results in greater longevity of the population, as shown today with the fastest growing area of the population being over age 70 (**Figure 1-6**).

Life expectancy of less than 50 and medical expenses primarily paid by one’s family have changed dramatically since 1900. In 2000, a person in the United States would be expected to live to 75 years of age and usually die in a hospital with most expenses paid by Medicare.⁴ Today, we cannot only prolong the natural lifespan through improved care, but we can also avoid decisions around death and dying for longer periods of time with greater monetary costs applied to the system. Reports of expenditures have indicated that more money is spent in the first and last 2 years of life than at any other point in a lifetime. This results from the current configuration of health care and community services along with gaps in the health care systems.⁵

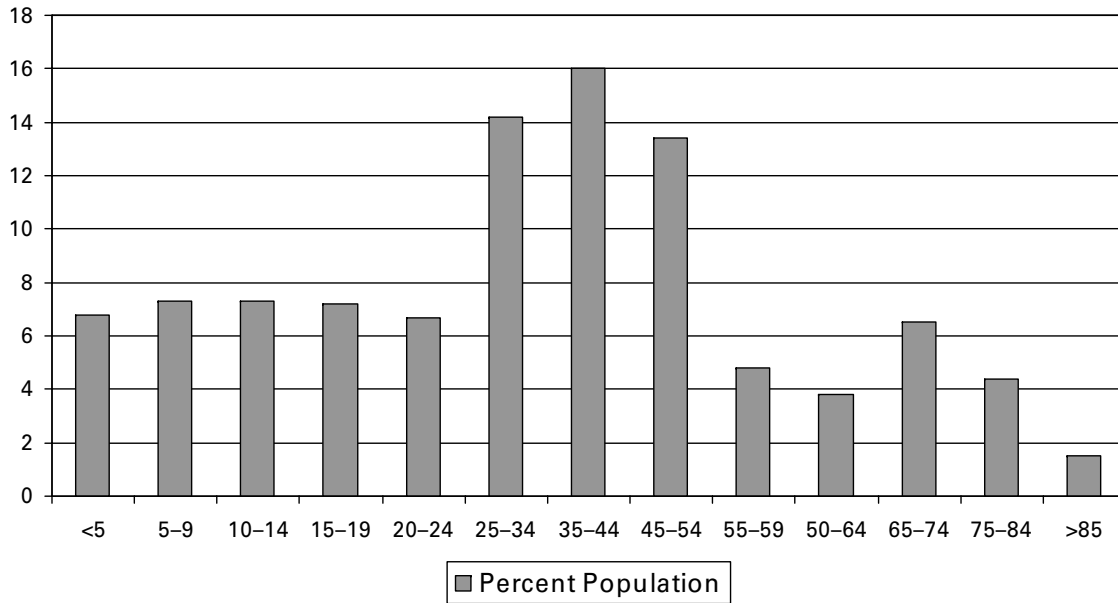
Razor Thin Margins and Uninsured Population

Private sector employers have felt the increasing squeeze of health care expenditures impacting their ever-shrinking profit margins, and state governments responsible for Medicaid have also been impacted as their revenues have fallen over the past few years. Citing increased spending and an expanded number of Medicaid recipients (**Figure 1-7**), states remain concerned about the steady to growing number of uninsured patients who ultimately need their health care service costs covered by governmental or employer-funded sources of revenue. Hospitals and health plans seek to recover the uninsured bad debt from providing needed care through health plan premium adjustments, state-free care pools, or other plan management changes that ultimately impact all payers in the health care system. The uninsured patients represent not only a moral dilemma in the United States, but a serious fiscal drain on private sector growth along with a fiscal instability felt at all levels of government.

Political Initiatives

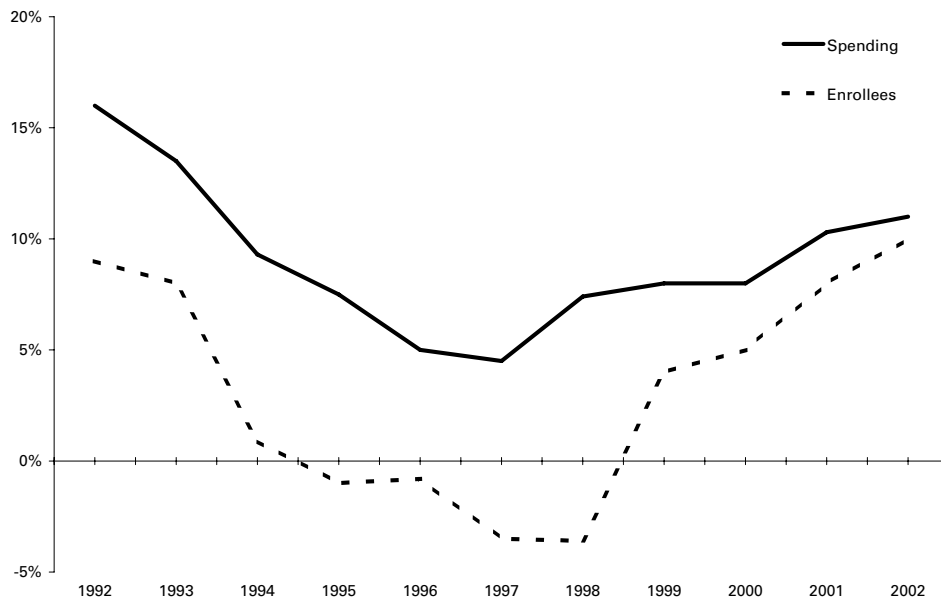
Ever since the failure to pass the President Clinton-backed Health Care Reform initiative in the late 1990s, the lack of political will to make tough decisions has left answers to be determined by the marketplace. While both political parties acknowledge the solvency issue, disagreements have been focused over the timing of bankruptcy and how best to deal with current versus future beneficiaries of these enormous entitlement and insurance programs. Now, President George W. Bush has continued attempts since late 2004 to promote the

FIGURE 1-6
U.S. General Demographic Characteristics, 2000



Source: U.S. Census Bureau, Census 2000.

FIGURE 1-7
Growth in Total Medicaid Spending and Enrollment, 1992–2002



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

new Medicare part D benefit as well as plans to improve solvency of both Medicare and the Social Security programs.

Health Care Reform

Regulatory initiatives, such as ambulatory payment codes (APCs), Health Information, Portability and Accessibility Act (HIPAA), and Medicare Part D, are changing the landscape of health care payment and the services provided in the United States. These efforts to contain rising health care costs while minimizing population coverage restrictions has led to new initiatives to coordinate benefits among the various government-sponsored or -managed programs. For example, Medicare and Medicaid benefits are being coordinated between the two programs to eliminate incentives for moving patients between different levels of care settings as well as integrating prescription drug coverage under one program. While these changes are positive and aid in slowing down spending, Medicaid currently strains most state budgets as one of their largest programs. Medicare will contribute to the growing federal budget deficits as one of the largest federal programs unless significant financing or benefit reforms are passed.

Social Security Reform

According to the trustees, Medicare will be as big as Social Security by 2024 and two times larger by 2079. Social Security is not in crisis today, but it does face a \$4 trillion shortfall during the same time that Medicare balloons in size.⁶ Building upon earlier initiatives around financing adjustments as well as greater individual control over retirement investments, the current Bush administration has been seeking to extend the solvency of the Social Security program. Both political parties have been prolonging bankruptcy of the program through technical changes or increased funding schemes, but they have not dealt with the underlying solvency issues of demographics and financial contributions.

Disillusionment of Managed Care

While state and federal wrangling continues over how best to finance the growing burden of health care, the private sector had readily embraced managed care in all its forms only to find it too could not contain the rising costs for health care. Both public and private sectors are seeking to utilize managed care principles while incorporating concepts of universal health care in newer plan offerings.

Consumer Entitlement

Since the advent of employer-sponsored health care, Social Security, and Medicare, consumers have begun to look at health care as an entitlement rather than a privilege. During post-World War II and subsequent economic booms, such a funding approach could be

sustained in the United States. Today, however, slowed economic growth combined with higher costs for health care have caused public and private payers to make moves to change the funding paradigm. As a result, consumers have been increasingly targeted for higher cost sharing as well as being given more decision making opportunities within employer-sponsored programs or CDHPs. These shifts to educate consumers and share the cost burden have broken down much of the entitlement mentality for the active working population, but they have caused resentment among retirees who remain in an entitlement mentality.

Population

Aging Population

The United States has continued to age, as seen in Figure 1-6. As a result, this country has an increasing health care burden coupled with an ever extending and longer lifespan. Today it is not unusual to hear of persons over 100+ years old and 75 year olds who are as active as 60-year-old seniors.

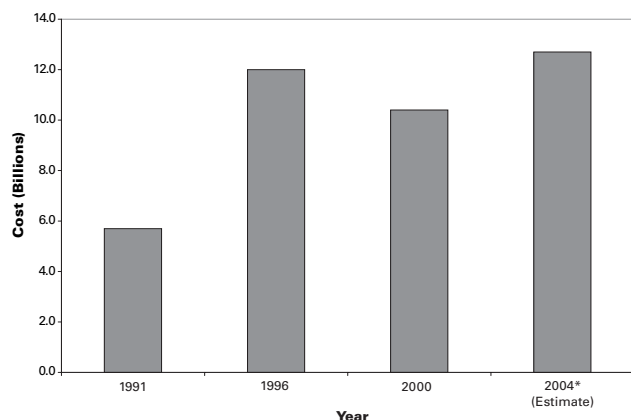
Growth in Chronic Disease Cases

Along with the aging of the U.S. population and improvements in health care technology, there has been significant attention around chronic diseases versus acute illness. The success of vaccines and antibiotics, public health measures, and aggressive seeking of emergent medical care have resulted in a greater number of persons living with chronic disease and for longer periods of time. Diabetes used to be considered a killer of young insulin-dependent patients 25 years ago, but today it causes little alarm and children can live virtually normal lives. Spending on diabetes grew to over \$12 billion in 2004 (**Figure 1-8**). Interestingly, advances in medical science have also been able to convert a deadly acute disease like HIV/AIDS into another version of a chronic disease, such as heart disease. Spending increases for heart disease doubled from 1992 to 2004 (**Figure 1-9**).

Health Care Workforce Shortages

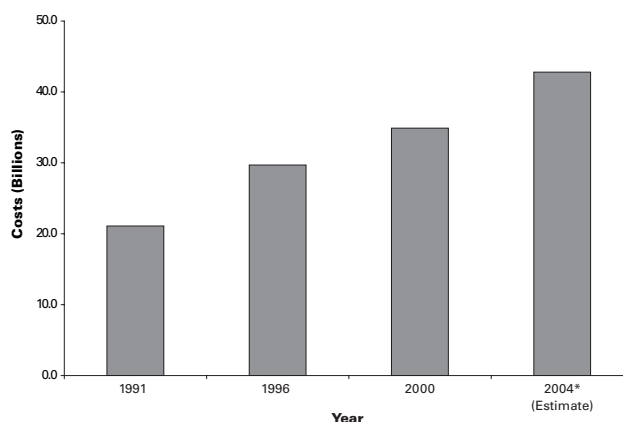
Increasing shortages in health care providers are more common in all care settings with an aging and retiring workforce, changing perceptions of health care workers, and costs associated with professional training versus income potential (**Figure 1-10**). Not only is the nation experiencing an increase in recruitment difficulties and nursing shortages but the decrease in medical specialties, pharmacists (**Figure 1-11**), and medical technicians is fueling a rise in health care costs as organizations seek to retain or recruit workers who demand higher salaries and benefit packages. Surveys assess the related workforce commitment in many sectors of the U.S. economy, including health care services. Fortunately for health care, workforce com-

FIGURE 1-8
Estimates for Chronic Disease
Spending: Diabetes, 1991–2004



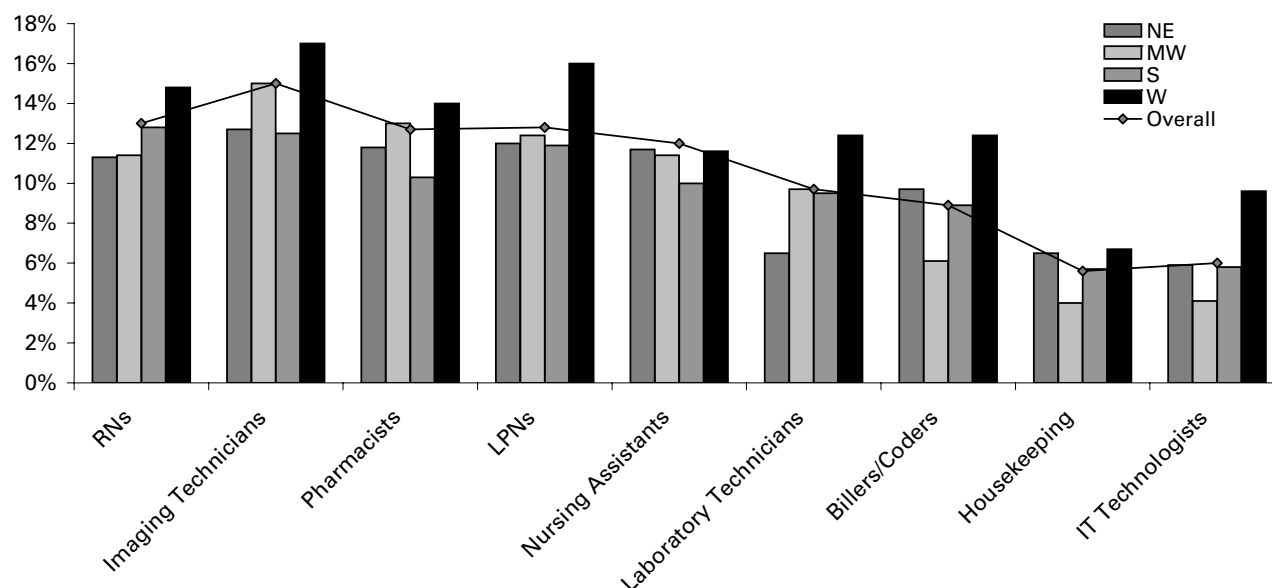
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, June 2002.

FIGURE 1-9
Estimates for Chronic Disease
Spending: Heart Disease, 1991–2004



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, June 2002.

FIGURE 1-10
Health Care Workforce Shortages by Area of Country



Source: Adapted from First Consulting Group, Report on Healthcare Worker Shortages, 2001.

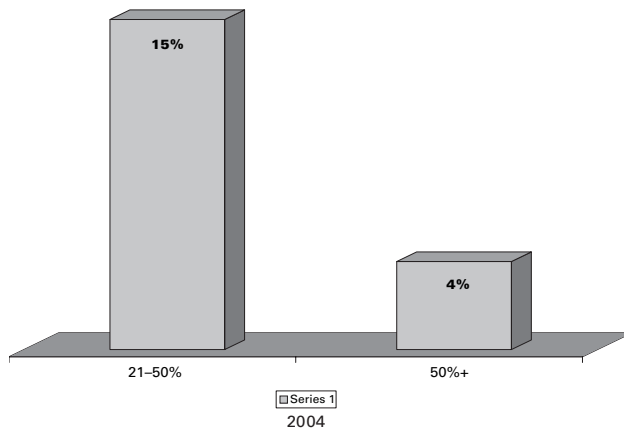
mitment has essentially remained unchanged from 2000 through 2003.⁷ Profiles of commitment by organization type or job category in the Healthcare@Work data set can be seen in **Figure 1-12**.

Concerns about these shortages also relate to a parallel interest in ensuring patient safety. Several states have now enacted mandatory error-reporting forms and

are promoting a culture of patient safety. The goals are generally to improve upon patient safety in delivering health care services and reduce medical liability exposure (**Figure 1-13**).

Many efforts were built upon the landmark 1999 Institute of Medicine Report entitled “To Err is Human,” which estimated that 44,000–98,000 preventable

FIGURE 1-11
Organizations Reporting Recent Rise in Health Care Labor Costs



Source: Adapted from First Consulting Group, Report on Healthcare Worker Shortages, 2001.

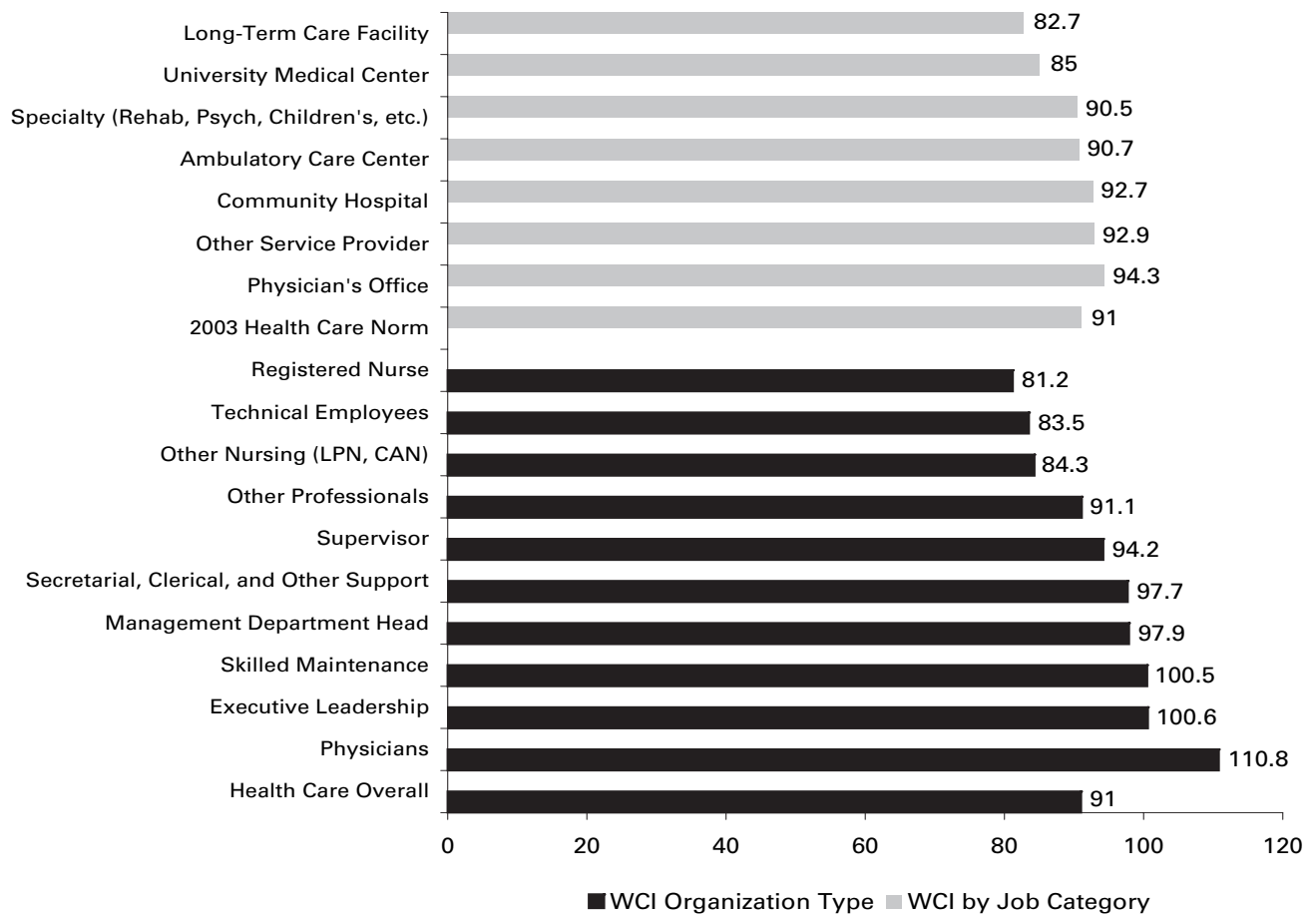
deaths occur each year as a result of medical adverse events.⁸

Inadequacies or Barriers in Current System Affecting Pharmacy

Financing of health care as we know it today has evolved through a series of political and economic influences since the 1900s. Payment for professional services emanated from the emergence of insurance to pay for hospital and physician care. Pharmacy was left behind as third-party insurance coverage grew. Eventually prescription drugs became covered through the advent of pharmaceutical benefit managers, and pharmacist services became entangled with that of dispensing a product (**Figure 1-14**).

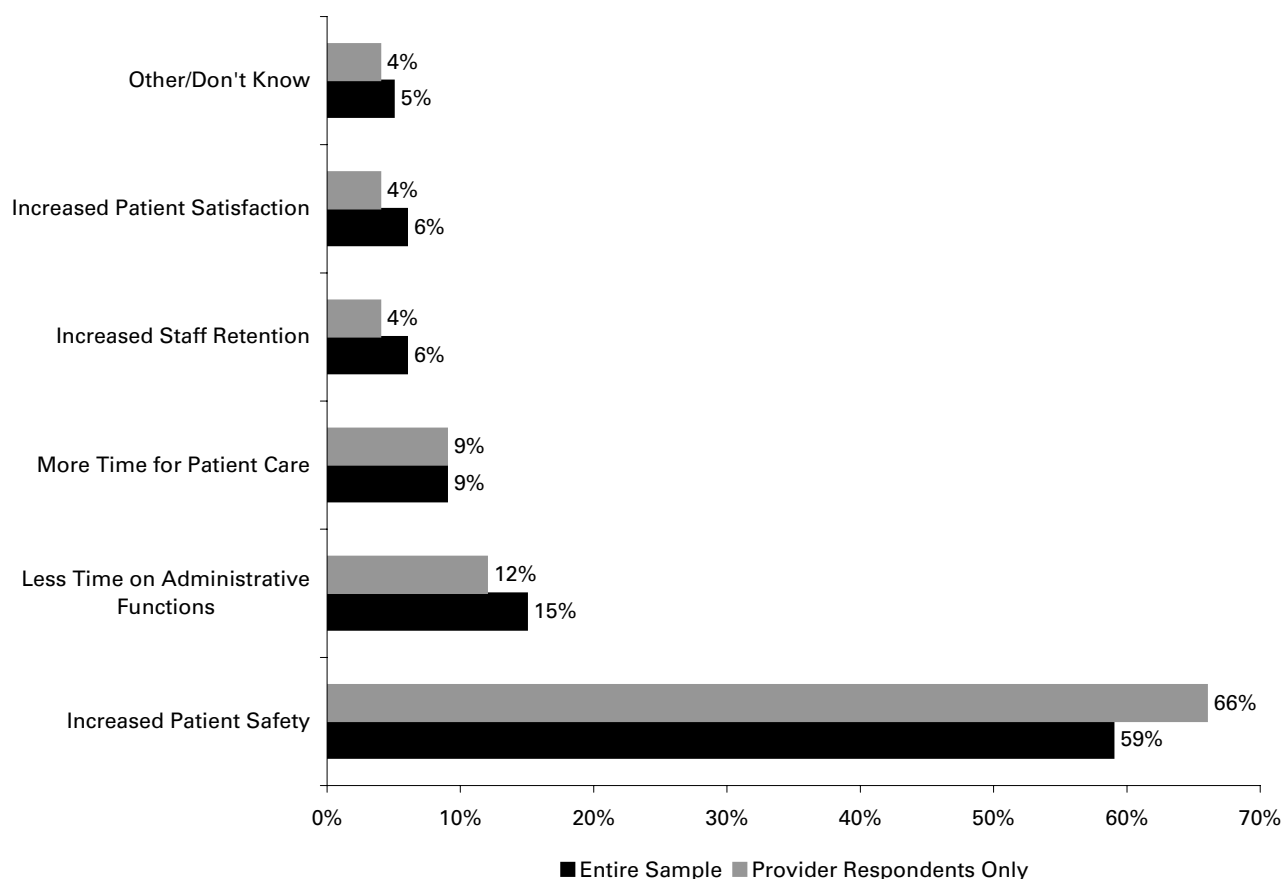
As a result, the dilemma has remained of defining payment for a pharmaceutical product or pharmacist professional service separately. Since the patient was essentially removed from decisions due to health plan and pharmacy benefit management (PBM) plans,

FIGURE 1-12
Profiles of Commitment by Organization Type or Job Category



Source: Aon Healthcare & Work, 2004. See reference 7.

FIGURE 1-13
Area That Will Benefit Most as a Result of Technology



Source: Adapted from HIMSS 2003 Technology and Staffing Survey, 2003.

decisions around what services would be covered became driven by both those same plans. This was true in both private and public sector programs. As a result, what was in the best interest of the plan and its overall expenditure management by line of service became the new battleground for pharmacist reimbursement.

Limitations in Medicare coverage for prescription drugs as well as pharmacist services continues to be a barrier for pharmacists seeking payment for Medication Therapy Management Services (MTMS). That includes a lack of recognition in the Medicare laws and regulations for pharmacists to hold a provider status. Although private sector exceptions readily occur, broad-based acceptance and codification of pharmacists as legitimate health care providers—separate from dispensing of a product—remains elusive.

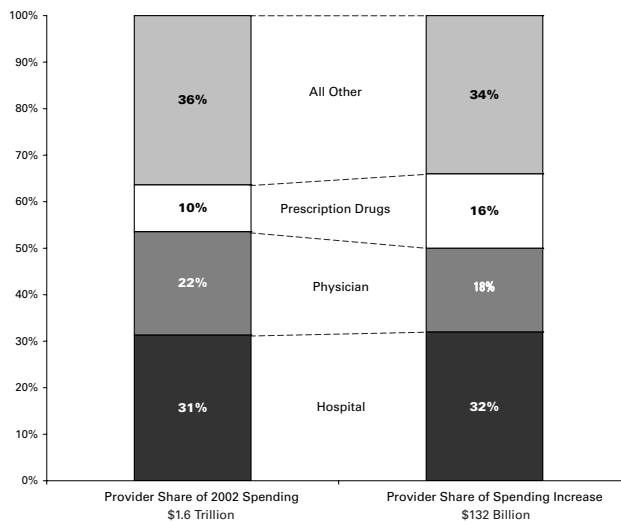
Continuing computer/IT system deficiencies and an inability to upgrade aging systems to easily accommodate shifts in product or professional fee reimbursement schemes have also contributed to the current status of pharmacist reimbursement. Competition for

scarce capital resource dollars, along with efforts to mitigate staff shortages, has indirectly impacted a willingness to change health care spending patterns (**Figure 1-15**).

Although computer systems are another barrier to change in health care delivery efficiencies, upgrades with new user-friendly technologies and integrated claims capability could allow for pharmacist professional fee reimbursement with other mid-level clinicians. Staffing is positively impacted through the introduction of new technologies and professional roles could continue to shift, thereby allowing for planned opportunities for pharmacists (**Figure 1-16**).

The shift in the 1990s to Pharm.D. programs as the entry degree has brought about a change in the professional capabilities of the profession as a whole, but it has also created a shift in pharmacy from pharmacists as an employer to that of an employee. This pharmacist employee mentality mirrors that seen in the medical profession as physicians have become employees themselves, in hospitals and group practices owned by

FIGURE 1-14
Provider Shares of Health Care
Spending and Increases, CY 2002



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2004.

insurance or other for-profit corporations. The ways that these changes affect compensation and benefit practices will be closely followed as they are tied to the cost of providing health care.

One immediate result of employer-to-employee change is a lack of financial incentives for pharmacists to pursue residency and other training. Pharmacy graduates today are seeking different opportunities for professional rewards while saddled with greater levels of debt from their undergraduate professional training. The lure of growing salaries and comprehensive benefit packages take new graduates out of the pool for graduate studies or residency and fellowship training (**Figure 1-17**). To be successful in gaining reimbursement for MTMS, pharmacists and other health care professionals must understand the basic terms and personnel involved in managing this part of the U.S. health care system.

Payer Types

Government, public sector programs that are mandated or authorized through Congressional legislation and regulatory enactment include the following:

- Medicare, Title 19 of the Social Security Act—an insurance program run by the federal government with funding from consumers and federal government.
- Medicaid, Title 18 of the Social Security Act—an entitlement program funded by federal and state funds that is managed by the states with federal oversight.

- Workman's Compensation—federal and state-mandated insurance programs.
- Veteran's Administration—federally funded and operated health care program or service through the Cabinet-level Department of Veterans Affairs.
- Indian Health Service—federally funded and operated through the Bureau of Indian Affairs.

Private sector programs that are offered through what is known as the commercial market include indemnity (coverage as costs are incurred) or managed care (coverage designs to manage costs) insurance plans. Unlike public sector programs, there are several types of private sector programs and numerous payers.

Self-funded employers refer to those larger employer organizations that ensure themselves and contract with health plans to provide coverage to their employees and families. Examples of self-funded employers include most of the Fortune 500 firms like Microsoft, General Motors, McDonalds, IBM, and Coca-Cola.

Patients also contribute to payment of services through traditional health plans like Blue Cross and Blue Shield, Aetna, Cigna, Humana, and United Health Care. Patients may pay a premium for health insurance or choose not to be covered and be a private (cash) payer. The vast majority of Americans are enrolled in some type of an insured program, whether a public or private sector-initiated health plan.

For people who do not have coverage or are unable to pay, indigent care programs are available. One is a program for medications known as 340b that is administered by the Department of Health and Human Services, Public Health, and Professional Services branch. This medication program allows for federally funded health centers and other eligible organizations to purchase medications at the best available price in the market similar to Medicaid price guarantees (pssc.aphanet.org/about/whatisthe340b.htm, accessed May 1, 2005).

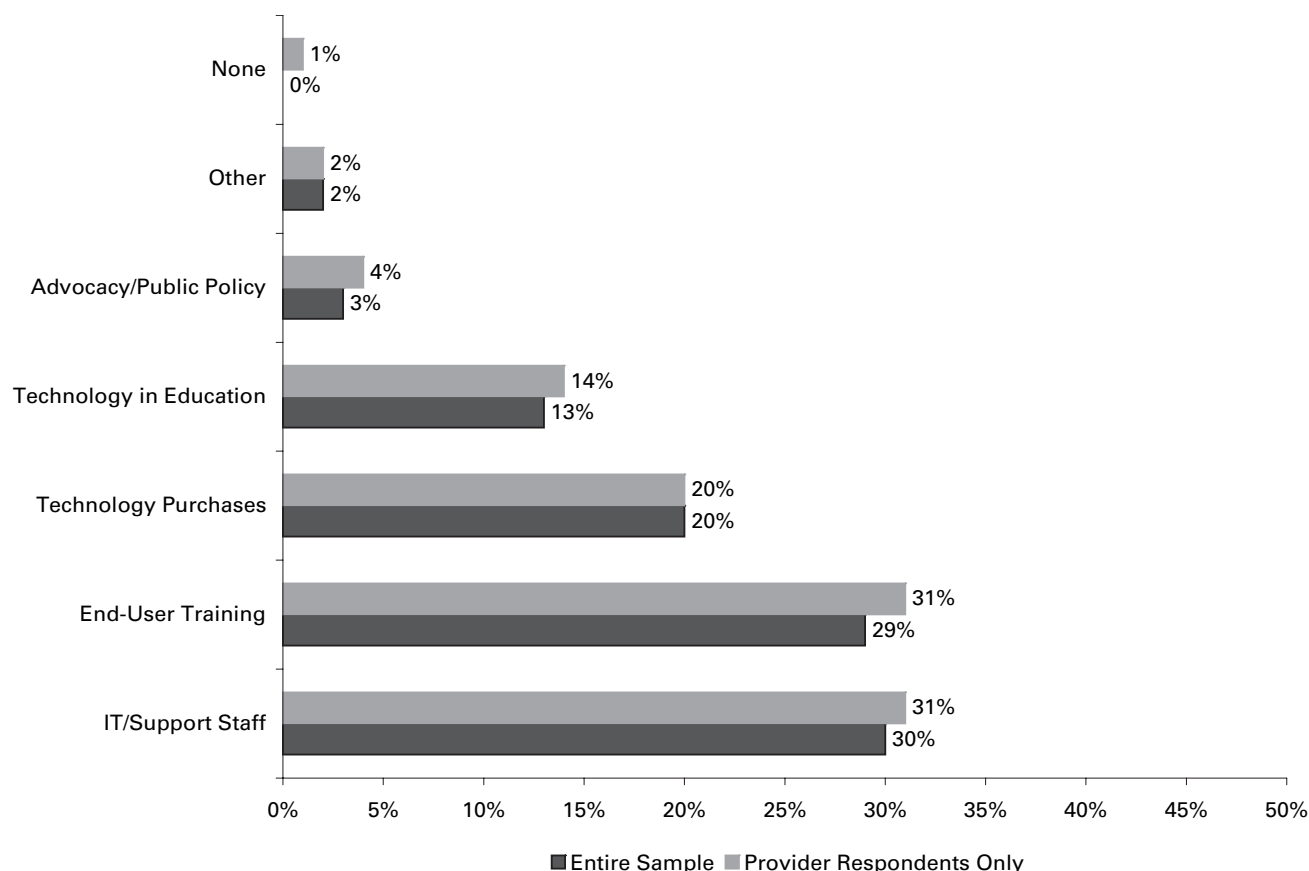
Another form of payment for health care services comes through grants provided by private- or public-based organizations. These grants include the Red Cross, health care charitable foundations, and government agencies with funds to provide catastrophic or specific care reimbursement for eligible patient populations. Finally, many states have established a method to provide as well as reimburse for charity and uncompensated care. These funding pools may come through provider payment fees, tax deductions, or professional fee withholdings by payers to be redirected into a free care pool on behalf of eligible patients.

Internal to Institution

For hospitals and other health care institutions, groups of individuals are responsible for handling or managing reimbursement issues for the organization. Those

FIGURE 1-15

Areas in Which Health Care Industry Should Denote Resources to Mitigate Staffing Shortages



Source: Adapted from HIMSS 2003 Technology and Staffing Survey, 2003.

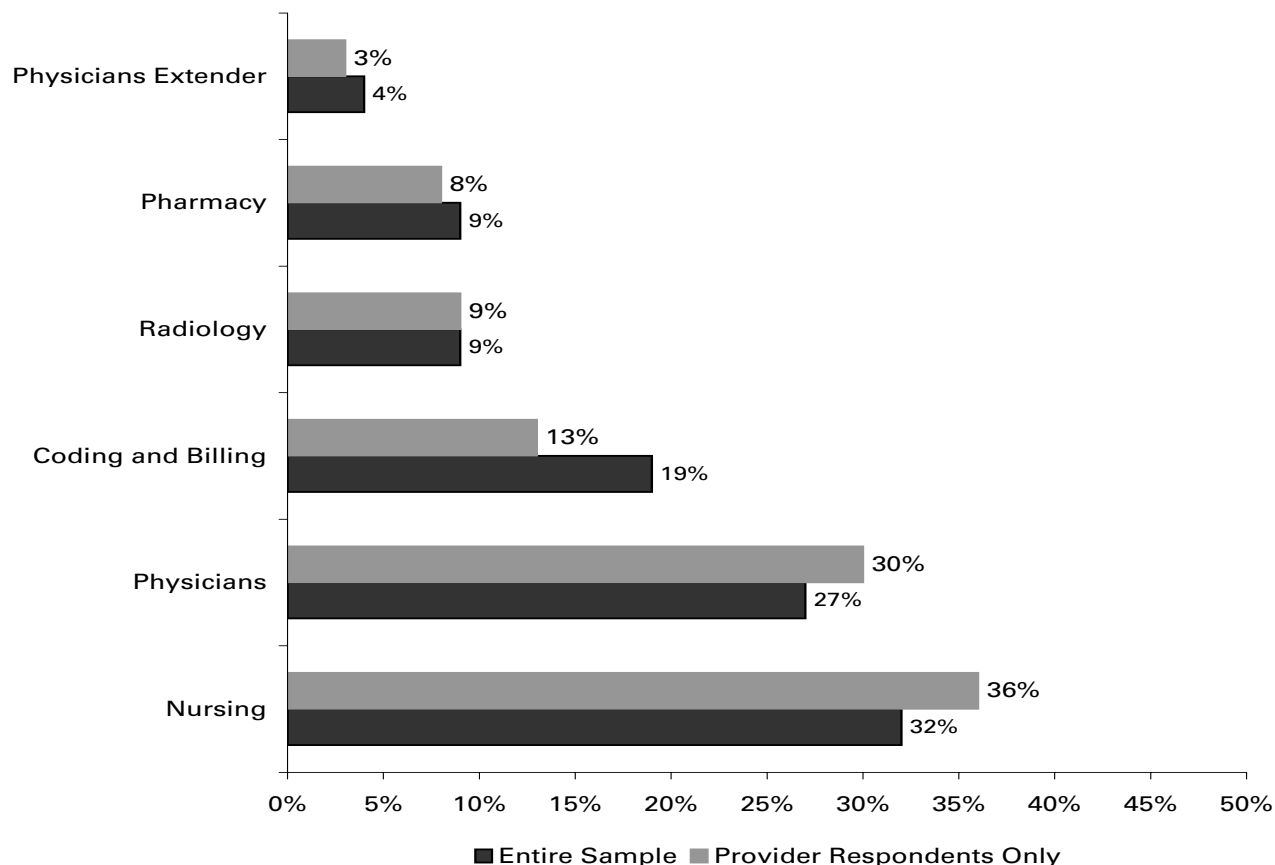
internal to the organization are personnel that should be known by pharmacists; they include the following:

- Processors, which include financial counselors, analysts, accountants, and others who work in collaboration with the Chief Financial Officer (CFO) to match patient coverage to payers. These personnel work to identify the top payer types for the organization, review contracts in light of areas of interest for reimbursement, and identify potential system changes required to make certain that the organization gets paid for its services.
- Professional coders and medical records personnel who evaluate coding options for the services rendered as well as ensure proper coding for billing of those services. They are a resource for pharmacy and other professional staff requiring education about proper documentation for services as well as the coding derived from that effort. This group also works with professional groups within the institu-

tion around any forms needing amendment(s) or changes to ensure reimbursement.

- Admitting or registration staff also plays a role in the documentation of patient care services and many times are the first line in the coding process. As a result, they need coding education and related service timelines should pharmacy services be part of the services billed for by the institution.
- Pre-certification and discharge planning staff are responsible for ensuring appropriate levels of and length (time) of care provided by the organization. They may be nurses or medical record professionals who use government or private recognized guidelines, such as InterQual, Milliman, Medicare, and Medicaid.
- Patient accounting, billing, collections, laboratory, and clinical staff represent other personnel that would be part of the pharmacy contact chain related to billing for professional services. Awareness and

FIGURE 1-16
Professional Area Most Positively Impacted by Technology



Source: Adapted from HIMSS 2003 Technology and Staffing Survey, 2003.

coordination of work among these personnel can go a long way toward making it easier for pharmacists to establish an error-free documentation and billing system.

Oversight

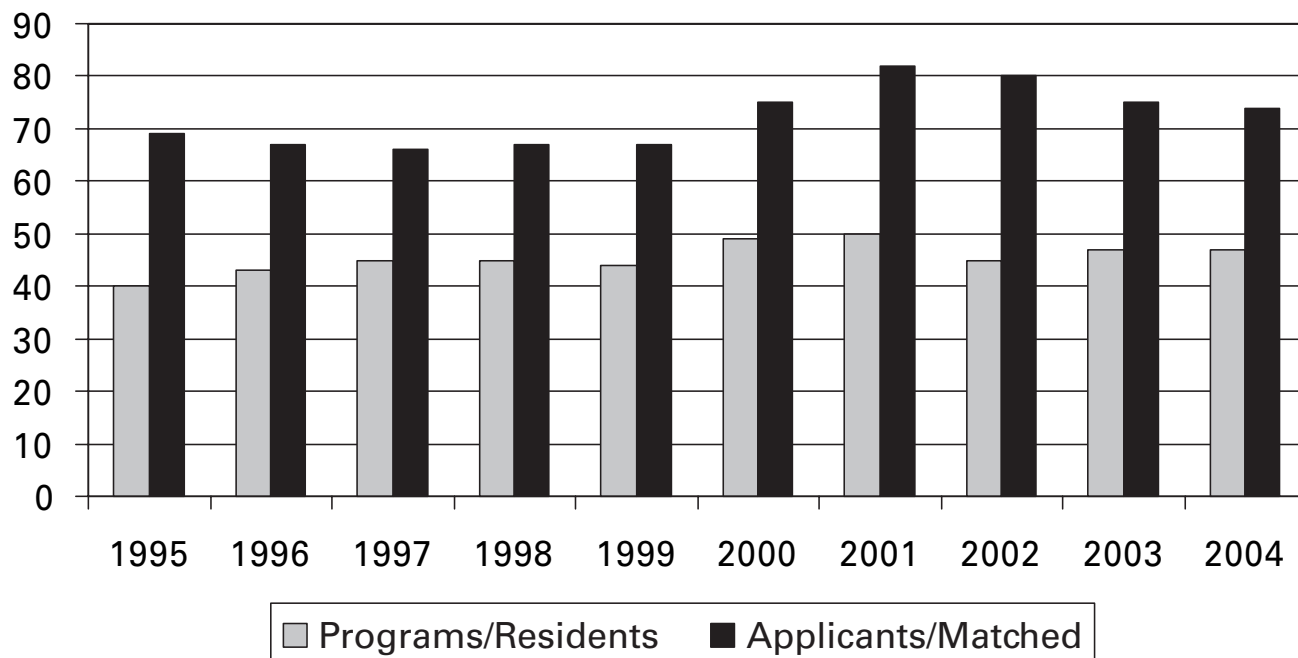
Due to the highly regulated industry and oversight of care in institutions, key personnel within the organization have specific responsibilities to ensure compliance with all laws or regulations. The Chief Financial Officer would be responsible for financial accounting, reimbursement analyses, and related contracting staff; the Chief Information Officer for system changes required, billing form revisions, and general IT support to staff who access or use the system; and revenue management staff, generally under the CFO, who have specific responsibility for ensuring optimal as well as prompt payment for appropriately billed services. Finally, Quality and Compliance Officers are responsible for professional staff credentialing, accreditation, HIPAA

compliance, and other applicable state or federal regulations affecting the direct provision of patient care services. This list may not be complete, but it provides pharmacists with a good starting point for understanding some key players and their responsibilities when interacting with pharmacists who are seeking payment for MTMS.

External to Institution

Those entities and personnel outside of a health care institution generally deal with the regulatory mechanisms of payment, compliance to law or regulation, and financial payment itself to an organization or approved provider supplying covered health care services to enrolled patients. These agencies are typically oversight in the public sector or contracting contacts for agreements with private sector health plans or insurers. They are the third party, nonpatient personnel who are responsible for ensuring adherence to provider service contracts as well as Medicaid and Medicare guidelines.

FIGURE 1-17
ASHP Residency Trend Statistics



This chart shows the total number of accredited programs and those pharmacist graduates who have applied for a Pharmacy Practice Residency. This does not include Specialized residency statistics. It also shows the total number of pharmacist applicants to positions matched through the ASHP matching program from 1995 through 2004.

Source: ASHP, July 2005.

Regulatory and Legal

Formerly known as the Health Care Finance Administration (HCFA), CMS is the federal agency responsible for administrative and finance functions to operate the major U.S. health care programs. Under the administrative branch of government, CMS promulgates regulations and administrative advisories based upon federal law. These regulations and advisories provide the basis for operating programs such as Medicare or Medicaid, including payment for services.

Office of the Inspector General (OIG) is an investigative and oversight unit found in every major federal agency. OIG has responsibility for determining fraud or abuse violations as well as general compliance with the intent of federal law that affects a federal agency such as CMS.

Congress is the federal legislative branch of government that promulgates and passes legislation that becomes federal law when signed by the President of the United States. Congress has two branches, the House of Representatives and the Senate. Laws passed by Congress are then made operational through federal or state agencies of the U.S. government, such as CMS.

Similar to the federal government structure, state legislators enact state laws that are then made operational through state agencies, such as Health and Human Services. State Inspector General and/or Attorney General are two offices within the state government responsible for determining fraud or abuse violations, criminal or civil violations of state law, and general compliance with the intent of state laws or regulation.

Private

Pharmacy is the business entity that provides prescription and nonprescription medications. The pharmacy employs pharmacists that are legally required to provide the dispensing, review, and clinical integrity of the prescriber's prescription(s).

Medical directors, case managers, pre-certification, discharge planning, network management, contractors, and network managers are employed by insurers, PBM firms, and other health care management organizations to provide operational support to the execution of benefit program. Although they have different responsibilities or scope of control over payment for services, all

of these positions can be involved in the care of an individual patient, including coordination of appropriate services.

Summary

Issues surrounding the financing of health care and the subsequent payment for providing professional services, including pharmacists, were reviewed in this chapter. The state of the U.S. economy and health care financing were discussed, along with the impact on employers and their demands on the health care system. Understanding the macroeconomics and higher level financing dilemmas provides pharmacists with information to better determine how best to position themselves for reimbursement as well as the difficulty in gaining acceptance as another provider seeking reimbursement.

Key trends and health care programs, such as the aging population, financing dilemmas, and different payer sources, were discussed in order to make pharmacists aware of the complexities in the health care

delivery payment system. Specific programs in the public or private sector, such as Medicaid, Medicare, and managed care plans, were reviewed. The coordination of benefits among the programs and the growing integration of coverage for professional services were also discussed. These aspects are important for pharmacists to know and to follow the emerging trends that will affect payment for MTMS by all providers, including pharmacists.

Finally, providing key terms and personnel that are either external or internal to a health care organization were provided in this chapter. It is important for pharmacists as practitioners to work beyond traditional practice boundaries if they are to be seen as health care professionals who can provide a billable professional service. Understanding the rules and players can provide an important platform for maintaining compliance with the numerous regulations that drive health care reimbursement.

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