Reforming Health Care Delivery in the United States

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Background

The United States is the only Western industrialized nation in the world that does not provide some form of health care coverage for all of its citizens.[1] We spend more on health care both per capita and as a percentage our gross domestic product than any other country in the world, yet we rank near the bottom among other industrialized countries in many public health measures such as infant mortality, life expectancy, and the percentage of children receiving immunizations.[2,3,4,5] While wealthy and well-insured residents of our country receive world-class medical care, more than 43 million U.S. citizens who have no health insurance,[6] and many more who are underinsured, receive inadequate care or no care at all.[2] In California, more than seven million people (20% of the state's population) lack health insurance.[7]

Clearly, being uninsured or underinsured in the United States is hazardous to one's health. Medical research shows that being uninsured is associated with a greater risk of preventable health problems, more advanced disease at the time of initial diagnosis, and premature death.[8] The overall rate of survival five years after being diagnosed with cancer for patients in the United States is comparable to rates in Canada, Japan, and Northern Europe,[9,10] and higher than in most other industrialized countries, but cancer survival rates are significantly lower in uninsured and underinsured patients.[11] One study showed that adults from ages 50-64 were 43% more likely to die if they lacked medical insurance.[12]

Health insurance costs and health care expenditures have been rising at a rapid rate for decades in the United States, far outstripping growth in wages and gross domestic product (GDP). Health care spending has risen from 5% of the GDP in 1960 to 18% in 2010.[13] Nearly half of personal bankruptcies in the U.S. occur as a result of unanticipated health care bills.[14] The high cost of providing health care coverage for its workers and retirees was a major factor in the bankruptcy of General Motors in 2009.[15]

Lack of adequate health care insurance forces many patients who cannot get health care elsewhere to go to the Emergency Department (ED) where they know they will be treated, regardless of their ability to pay.[16] Studies show that 80% of all California ED visits by uninsured or Medi-Cal patients are for

conditions that could have been treated in a non-ED setting.[14] The flood of uninsured and underinsured patients seeking primary care in California's ED's has contributed to overcrowding, ambulance diversions, and severe financial strain on the emergency care system. The California Medical Association estimated that in 2002, uncompensated ED care in California totaled $635 million.**Error! Bookmark not defined.** Since 1990, 65 ED's in California have closed as a result of this financial strain.

Three Main Factors Contributing to the Flawed U.S. Health Care Delivery System

1. The For-Profit Motive That Drives Most of U.S. Health Care Delivery

A fundamental flaw in the U.S. health care system is that health care is treated largely as a commodity distributed according to where it is most profitable rather than as a service distributed according to where it is most needed.[3] Because distribution of resources is driven more by profit than by medical need, there is an oversupply of physicians and advanced medical equipment in wealthier urban and suburban areas, and a lack of physicians and equipment in poorer rural areas and inner cities.

There are also perverse economic incentives in the health insurance industry. Health insurance companies and Health Maintenance Organizations (HMO's) profit by attracting younger, healthier people to their plans. For-profit health insurance plans frequently exclude coverage for persons with even the most minor pre-existing conditions, and such health plans typically focus advertising toward young, healthy populations. They also profit by putting in place co-pays, deductibles, and caps which require insured individuals to share a substantial portion of the cost of their care if they do become ill or injured. Paradoxically, the profit driven health care insurance system in the United States is designed to exclude coverage for those individuals most likely to need medical care.

While it may be argued that a free-market, for-profit system may operate for the common good in other areas of a capitalist economy, an un-regulated for-profit motive clearly does not serve the common good in areas such as health care in which there is a large imbalance of power between the supplier and the consumer. Health care insurers have sophisticated epidemiologic and actuarial data at their disposal and can set their premiums at the highest level that the market will bear. Individual health insurance consumers, on the other hand, have little idea when they will need health care or how much it will cost. And when individuals do become ill or injured, they usually do not have the luxury of shopping from provider to provider to get the best buy, or of waiting a month or two to see if the price might come down.

While critics of government-sponsored universal health care frequently dismiss such systems as “socialized medicine,” it is widely accepted that it is in the interests of the common good to have extensive government involvement in providing and regulating other services in our country in which there would be a large imbalance between the consumer and the provider if the services were run strictly for profit. Examples of widely accepted “socialized” services which are either provided or strictly regulated by the government include law enforcement and fire protection, public education, water and energy delivery, highway and bridge construction and maintenance, and public transportation.

2. Failure of the Government to Use its Purchasing Power to Leverage Down Health Care Costs

Individual health saving accounts have been advocated as an approach to reducing health care costs, based on the argument that individuals who have such accounts will negotiate with health care providers to get the best possible rates. The problem with this approach is that individual health care purchasers have very little negotiating power. Large purchasers such as the federal government, on the other hand, have substantial negotiating power.

A prime example of the U.S. Federal Government failing to use its purchasing power to negotiate lower health care costs is the Medicare Part D prescription drug plan. The pharmaceutical industry in the United States benefits from some of the highest profits and lowest taxes of any industry.[2] The pharmaceutical industry also has tremendous lobbying power. Drug makers have been able to get patent laws passed which are highly favorable to their industry, arguing that their companies spend large sums of money on research and development. In fact, though, the industry spends two and a half to three times as much money on marketing as it does on research.[17]

The 2004 Medicare Part D prescription drug bill, while touted as a benefit for seniors, was written largely by and for the drug industry.[18,19,20] The bill specifically prohibits the federal government from using its purchasing power to leverage drug companies into offering lower prescription drug prices for Medicare enrollees. One of the main proponents of the bill, Rep. Billy Tauzin of Louisiana, resigned as a Congressman and chairperson of the House Committee on Energy and Commerce, which oversees the pharmaceutical industry, after the Medicare Part D bill passed to become president and CEO of the Pharmaceutical Research and Manufacturers of America, the main lobbying group for the pharmaceutical industry, at a reported annual salary of $2 million a year.[21] Because of the prohibition on negotiating lower drug prices in the Medicare Part D bill, Medicare enrollees pay much more for prescriptions than patients covered by the Department of Veterans Affairs, which does negotiate with pharmaceutical companies for lower prices.[22]

The failure of the federal government to use its purchasing power to leverage down health care costs and the example of the Billy Tauzin incident are symptoms of a more pervasive problem with our system of government. The United States has been described as, “The best democracy that money can buy.”[23] As a result of the high cost of running for office in the United States and the fact that the candidate who spends the most money usually wins, most legislators are indebted to and unduly influenced by moneyed special interests. In the case of health care, examination of the Federal Elections Commission database of campaign contributions reveals that members of Congress on both sides of the aisle receive large contributions from the pharmaceutical industry, for profit hospitals and health insurers, and organized medicine.[24] It has been suggested that enactment of public campaign financing may be a necessary precursor to the enactment of a truly universal health care system in the United States. It is of note, in this regard, that the state of Maine, which enacted public campaign financing for governor and state legislators in 1996, created a state subsidized health plan as a voluntary option for state residents in 2003. Though the Maine health care system faces challenges, it has been credited with some expansion of affordable health care coverage to individuals who were previously uninsured.[25]

3. Administrative Overhead and Redundancy

A final problem with the U.S. health care system is inefficiency. A great deal of time and energy is wasted in the U.S. health care system in the completion of lengthy and often redundant billing forms by health care providers; review of these forms and, in some cases, denial of payment by health insurance administrators; and subsequent appeals of denied claims. As a result of redundancy in health insurance plans and lack of regulation of administrative costs, a much higher percentage of the U.S. health care dollar is devoted to administrative overhead than in other countries that have universal health care systems, or even in the U.S. Medicare or Veterans Administration health care programs which are much more efficient than the private health insurance industry.[3,26]

Moving Toward Universal Access to High Quality, Affordable Health Care for All U.S. Residents

The Sacramento Chapter of Physicians for Social Responsibility believes that the ultimate goal in reforming health care delivery in the United States should be to develop a system under which every resident has access to high quality, affordable health care, just as residents do in the other leading democratic industrialized countries of the world, while maintaining a choice of providers and incentives for advances in medical research and technology. A single payer system, under which the federal government replaces private insurance companies as the collector of insurance premiums (usually in the form of taxes)

and the payer of medical bills, is inherently the most efficient form of universal health care, and is the model used in the other English speaking democracies. Some European countries, though, such as Switzerland and Germany, have successful universal health care systems in which there are multiple payers (insurance companies), which are strictly regulated by the government.[27] A stepwise approach may be necessary to move from the current chaotic and inequitable health care delivery system in the U.S. to a system of universal access to affordable, high quality care, and proponents of single payer, universal health care should be willing to consider a multiple payer model as a transition stage toward the ultimate goal.

California Universal Health Care Legislation

Proposition 186, a bill to establish a single payer universal health care system in California, was placed on the ballot in 1994 through a grass roots campaign. Initial polling indicated about a 50/50 support to opposition ratio, but the initiative was ultimately defeated 73% to 27%. The large shift in public opinion was attributed to the success of for profit health insurance companies, hospitals, pharmaceutical companies, and organized medicine invoking fears of “rationing,” “socialized medicine,” and big government. An analysis of the defeat of Proposition 186 concluded, “Seriously ill as our health system is, it’s illness is not as severe as that of our democracy as a whole. We do not have a political culture that will support or sustain the kind of discussion and debate that is necessary for the electorate to be informed on any complex issue, of which health care is but one.”[28]

Other efforts to establish a single payer, universal health care system in California have been made through the State Legislature. SB 840, introduced by State Senator Sheila Kuehl, was approved by the Legislature in 2006 and again in 2008, only to be vetoed both times by Governor Schwarzenegger. If SB 840 had been signed into law, it would have established the framework for the California Health Care System. Under the system, over a transition period of several years, all current health insurance providers in the California would have been phased out, and the money now going to those insurers would have gone instead to the State Health Care Fund. The monies in the Health Care Fund would have been used to pay health care providers and to fund capital improvements. The bill was designed to cause little change in the way physicians practice medicine or patients chose their doctors. Physicians could continue to practice in fee-for service arrangements, in salaried or capitated group practices, or in academic institutions. Instead of billing patients or their insurers, however, physicians would bill the Health Care Fund, or would receive their salaries from this fund if they chose to work directly for the State.

Even if Governor Schwarzenegger had signed SB 840 into law, though, another funding bill would have been required to get the California Health Care System in operation, and such a bill would have either required a two third majority vote in the State Legislature or a state ballot initiative approved by the majority of voters. If SB 840 and a companion funding bill had been enacted, an independent analysis by the Lewin Group concluded that for the amount that Californian's are now paying collectively for medical care, while leaving 20% of the state's population uninsured, everyone in the state could have had high quality, comprehensive health care coverage, and most individuals or companies who are now paying for comprehensive health insurance would have seen a decrease in the amount they are paying. [29]

California State Senator Mark Leno introduced a similar single payer universal health care proposal in the 2009-2010 legislative session, but the bill died in the State Assembly. He has introduced the bill again as SB 810 in the 2011-2012 legislative session. The bill passed by a 6-2 vote in the Senate Appropriations Committee on January 19, 2012, and a vote of the full State Senate is pending.[30] If the bill passes in the Senate, it will also have to pass in the State Assembly before being sent to Governor Brown for his signature. As with Senator Kuehl's SB 840, passage of SB 810 would only establish the framework for a statewide single payer universal health care system, but such a system would not go into effect until a companion funding bill is either passed by a two thirds majority of the legislature or by a majority vote of the public through the initiative process.

Federal Universal Health Care Legislation

On March 23, 2010, President Obama signed the Affordable Health Care and Patient Protection Act (PPACA) into law. This bill, commonly referred to as the "Affordable Care Act" by its supporters and as "Obama Care" by its opponents, was by far the most ambitious piece of health care legislation to be enacted at the federal level since the establishment of the Medicare program in 1965 under President Johnson. The Medicare program, passed as an amendment to the Social Security Act, covers 80% of medical expenses for U.S. citizens age 65 and over and for younger patients with permanent disabilities or end-stage renal disease. The remaining 20% of medical expenses must be paid out of pocket or by private supplemental insurance plans. The original Medicare amendment did not cover prescription drug costs. As noted above, the Medicare Part D bill, passed in 2004 under President George W. Bush, added partial prescription drug coverage.

PPACA does not establish either a universal or a single payer health system in the United States. A true single payer universal health care bill was first introduced by Representative John Conyers (D-MI) in 2003 as HR 676, Known as the "Medicare for All" act, this bill would have extended Medicare-like coverage to all U.S. residents. Representative Conyers repeatedly introduced HR

676 between 2003 and 2009 and the bill garnered as many as 88 co-sponsors by 2009, but the bill never passed in the House of Representatives. Once debate began on PPACA in late 2009, support waned in Congress for the "Medicare for All" act. It is of note that the Medicare for All Act, which would have established a true single payer universal health care system in the United States, was 30 pages long whereas PPACA, which establishes partial coverage through multiple payers, is 906 pages long. It is also of note that all congressional Republicans and 34 House Democrats voted against PPACA.

Key Aspects of PPACA

- Prohibits insurance companies from turning down children with pre-existing conditions beginning in September 2010, adults in 2014
    - Creates a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions with maximum premiums no more than 4 times the rate for individuals without pre-existing conditions; maximum annual out of pocket expenses $6K for individual and $12K for family.
- Bans rescissions (canceling policy after holder gets sick) beginning Sept 2010
- Requires all "applicable individuals" to maintain "minimum essential coverage" beginning in 2014
    - All applicable individuals include all legal residents.
    - "Minimum essential coverage" may cover as little as 60% of medical expenses.
    - Beginning in 2014, applicable individuals who don't have health insurance will pay an annual fine of $95, or 1% of income, whichever is larger, if they don't have "minimum essential coverage."
        - Fine increases to $695 or 2.5% of income by 2016.
- Reduces "doughnut hole" in Medicare prescription drug coverage between 2011 and 2020
    - Doughnut hole gap in Medicare Part D occurs between $2,830 and $6,440. Percentage seniors pay in doughnut hole will gradually decline to 25% in 2020.
- Beginning in 2014
    - Expands Medicaid coverage to persons making up to 133% of poverty level ($14K)
    - Low income persons and families above the Medicaid level and up to 400% of the federal poverty level will receive federal subsidies on a sliding scale if they choose to purchase insurance via an exchange (persons at 150% of the poverty level would be subsidized such that their premium cost would be of 2% of income or $50 a month for a family of 4).
    - Imposes penalties on companies with >50 employees who don't offer insurance

    - Provides premium credits to individuals paying > 9.5% of income on health insurance or earning < 400% of poverty level ($44 K)
    - Establishes state-based health benefit exchanges through which individuals and small businesses may purchase health insurance
        - Bronze – covers 60% of out of pocket expenses below $6K for individuals, $12 K for families
        - Silver – covers 70% of out of pocket expenses
        - Gold – covers 80%
        - Platinum – covers 90%
- Requires insurance companies to spend at least 80-85% of premiums for clinical services, quality (2011)
    - Insurers in individual and small group markets must spend >79%, in large group market >84%.
- Establishes process for review of premium increases (2011)
- Prohibits annual and lifetime limits on coverage (2014)
- PPACA Financing
    - Cuts payments to Medicare Advantage private insurers (2011)
        - Medicare Advantage is Medicare administered by private insurance companies.
    - Reduces tax deductions for FSA's, medical expenses (2013)
        - FSA = flexible spending account. Money in FSA can be used to pay for health care. New limit will be $2,500/year.
    - Increase threshold for deductible medical expenses from 7.5% of earned income to 10% of earned income.
    - Increases taxes on individuals making > $200K, couples making > $250K (2013)
        - 3.8% tax on earned and investment income above 200K for individuals, 250K for couples.
    - Places excise tax on pharmaceutical companies, health insurance companies, indoor tanning services (2012)
    - Imposes excise tax on "Cadillac" insurance programs offered by employers (2018)
        - "Cadillac" defined as >$10,200 annual individual premium or > $27,500 family premium
        - Tax equal to 40% of value of plan over threshold limits
        - Tax would be paid by plan administrator or employer
- CBO estimates of fiscal impact of PPACA
    - Cost estimates over 1st 10 years
        - Increased Federal outlays for health care of $366 billion
        - Increased Federal income/savings from tax increases, reforms of $498 billion
        - Net reduction of budget deficit of $132 billion
    - Coverage estimates
        - Additional 36 million individuals insured
        - 18 million left uninsured

- Uninsured would include undocumented immigrants, persons choosing to pay penalties rather than insurance, persons covered by Medicaid who don't sign up.

Controversies and Criticisms concerning PPACA

- Individual mandate to buy health insurance
  - The constitutionality of the individual mandate has been challenged, with the Supreme Court due to hear the case in March 2012.
  - It has been argued that under the law of supply and demand, the individual mandate is likely to drive health care costs up.
    - Health care costs have continued to rise in Massachusetts since passage of an individual mandate in that state.
  - It has been argued that is unfair to mandate that individuals buy health insurance that is both over-priced and inadequate.
- No real curbs against rising health care costs
  - Health insurance costs rose 9% in 2011, one year after enactment of PPACA.[31]
- No "public option"
  - Under the "public option" originally favored by the Obama administration over the individual mandate, private citizens would have been able to purchase health coverage voluntarily through a government run health insurance plan.
  - Insurance companies strongly opposed the "public option," probably because they feared they could not compete with a government run health insurance plan which used its purchasing power to leverage down health care costs.[32]
- Will probably cost more than original estimates
- PPACA was written to satisfy the insurance industry, the drug industry, the hospital industry, business and organized medicine.
- Passage of PPACA will thwart efforts to pass more meaningful health care reform.
  - Due to the political rancor and negative public reaction over PPACA, Congress is unlikely to revisit the issue of universal health care any time in the near future.
  - Passage of the federal PPACA legislation could also discourage efforts at the state level to establish universal health care systems, though section 1332 of PPACA provides for the option of states to obtain waivers to establish their own plans.

Summary and Conclusion

PSR/Sacramento believes that access to necessary medical care in the United States should be viewed as a basic human right, not as a privilege based upon one's ability to pay. The other leading democratic, industrialized countries of the world have approached health care delivery with this philosophy for decades, and it is past time that the United States should join them. Because so many people in the U.S. lack adequate medical insurance, the U.S. ranks low in overall public health measures compared with most other democratic industrialized countries. U.S. citizens are already paying more for health care, on average, than the citizens of any other country in the world, but we are not getting what we pay for. The federal PPACA legislation passed in 2010 addresses a few of the inequities in our current health care delivery system, but does not adequately address the main problems. The citizens of the United States should not allow themselves to be fooled by scare tactics, including buzzwords such as "socialized medicine" and "rationing," but should instead engage in rational discussions of how to achieve truly universal access to necessary health care for all residents of our country. Although a single payer universal health care system may be the ultimate goal, proponents of universal health care should be willing to compromise in considering multiple payer and partial coverage systems as steps toward that ultimate goal. Finally, the citizens of the United States should insist that their elected officials act in the spirit of government "of, by, and for the people," not government of, by, and for special interests, not only in the arena of health care but in all other areas of public policy.

References

[1] Geyman JP. Myths as barriers to health care reform in the United States. International Journal of the Health Sciences 2003;33:315-329.
[2] The World Health Report 2000. Health Systems: Improving Performance. The World Health Organization.
[3] The Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the physicans' working group for single-payer national health insurance. JAMA 2003;290:798-805.
[4] Starfield B. Primary Care: Balancing Health Needs, Services, and Technology. Oxford University Press, New York, 1998.
[5] Organisation for Economic Cooperation and Development Health Data 2011 – Frequently Requested Data. Available at http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html. Accessed January 25, 2012.
[6] Mills R, Bhandan S. Health insurance coverage in the United States:2002. Washington, DC: Us Dept of Commerce;2003. Current Population Reports P60-223.
[7] A system in continued crisis. CMA's 4th annual ER losses report. Available at http://www.cmanet.org/publicdoc.cfm/574/1#12
[8] Hoffman C, Paradise J. Health insurance and access to health care in the United States. Ann N.Y. Acad. Sci. 2008;1136:149-160.
[9] Verdecchia A, Francisci S, Brenner H, et al. Recent cancer survival in Europe: a 2000-02 period analysys of EUROCARE-4 data. Lancet Oncol 2007 Sep;8(9):784-96.
[10] Coleman MP, Quaresma M, Berrino F, et al. Cancer survival in five continents: a world-wide population-based study (CONCORD). Lancet Oncol 2008 Aug;9(8):730-56.
[11] McDavid K, Tucker T, Sloggett A, Coleman MP. Cancer survival in Kentucky and health coverage. Arch Intern Med 2003;162:2135-44.
[12] McWilliams JM, Zaslavsky AM, Meara A, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Aff (Milwood). 2004;23:223-33.
[13] Centers for Medicare and Medicaid Services. National Health Expenditures Summary. Available at https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage. Accessed January 25, 2012.
[14] Jacoby MG, Sullivan T, Warren E. Medical problems and bankruptcy filings. National Bankruptcy Advisor 2000.
[15] Currie A, Cox R, Hutchinson M. G.M. bankruptcy loomed for years. New York Times. June 1, 2009.
[16] Richardson LD, Hwang U. Access to care: a review of the emergency medicine literature. Academic Emergency Medicine 2001;8:1030-1036.
[17] Light DW, Lexchin J. Will lower drug prices jeopardize drug research? A policy fact sheet. The American Journal of Bioethics 2004;4:W3-W6.
[18] Iglehart JK. The new Medicare prescription drug benefit - a pure power play. N Engl J Med 2004;350:826-833.
[19] Kennedy EM, Thomas B. Dramatic improvement or death spiral - two members of Congress assess the Medicare bill. N Engl J Med 2004;350;747-51.
[20] Pear R. Bush aides put higher price tag on Medicare law. New York Times. January 30, 2004.
[21] Pear R. House's Author Of Drug Benefit Joins Lobbyists, New York Times. December 16, 2004.
[22] Hayes JM, Walszak H, Prochazka A. Comparison of drug regimen costs between the Medicare prescription discount program and other purchasing systems. JAMA 2005;294:427-428.
[23] Palast G. The Best Democracy that Money Can Buy. 2002. Pluto Press. London.
[24] Lists of campaign contributions for members of Congress are available at http://www.fec.gov/disclosure.shtml.
[25] Belluck P. As health plan falters, Maine explores changes. New York Times. April 30, 2007.
[26] Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med 2003;349:768-75.
[27] Reinhardt UE. The Swiss health system: regulated ocmpteition without managed care. JAMA 2004;292:1227-31.
[28] Farey K, Lingappa VR. Journal of Public Health Policy 1996;17:133-152.
[29] Spelman, J, in Speech to the Annual Conference on Managed Care, September 15, 2003, in Long Beach, California, citing study by the Lewin Group.

[30] Van Oot T. California single-payer health care bill to get full Senate vote. Sacramento Bee January 19, 2012. Available at http://blogs.sacbee.com/capitolalertlatest/2012/01/california-single-payer-health-care-bill-to-get-full-senate-vote-redevelopment.html#mi_rss=Capitol%20Alert#storylink=misearch. Accessed 1/24/12.
[31] Abelson R. Health insurance costs rising sharply this year, study shows. New York Times. September 27, 2011.
[32] Stolberg SG. 'Public Option' in health plan may be dropped. New York Times. August 17, 2009.