

On the Road to Universal Healthcare Coverage: Where Are We Headed?

By Jim Lott, HASC Executive Vice President

Three prominent healthcare organizations – the Institute of Medicine, the Blue Cross/Blue Shield Association and the American College of Physicians – simultaneously issued reports in January calling for either universal healthcare coverage or the dramatic expansion of the safety net for the nation’s uninsured. The recommendations ranged from overhauling and merging the Medicaid and state Children’s Health Insurance Programs to establishing a single-payer system.

“In light of the adverse consequences that (lack of insurance) has for individuals, families, communities and society as a whole, it should be painfully clear that our nation can no longer afford to ignore this problem,” said Arthur Kellermann, MD, chair of emergency medicine at Emory University School of Medicine in Atlanta and chair of the IOM committee that issued the report.

That three organizations representing

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constituencies as divergent as researchers, payers and providers would call for such a dramatic restructuring of U.S. healthcare delivery illustrates what has been an increasingly troubled time for the sector.

According to U.S. Census Bureau

data, the number of uninsured Americans is approaching 44 million, a figure that increased 9.5 percent between 2000 and 2002. Thirty-eight percent of Americans under the age of 65 – a total of 85 million people – went without insurance for a time between 1996 and 1999. More than half went without coverage for more than a year.

In a report separate from the one issued in January, the IOM concluded that 18,000 Americans die every year because they lack healthcare insurance. When they do receive care, it is often after they’re already ill, and is of a lesser quality than that received by individuals with coverage.

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The Uninsured: A Growing Middle-Class Problem

Although the majority of those without insurance are in the lower income groups, 80 percent of those without coverage hold jobs. An increasing number are part of the middle class. The fastest-growing group of the uninsured earn between \$25,000 and \$50,000 a year. Some 14 million uninsured individuals earn more than \$50,000 a year, while 7 million earn more than \$75,000.

Those with either individual or employer-based healthcare coverage are also bearing a greater financial burden. Although overall healthcare costs increased 8.5 percent in 2003, insurance premiums

increased an average of 13.9 percent. With per capita employee healthcare costs approaching \$6,000 annually, cost shifting has caused the average out-of-pocket cost per insured individual to increase 50 percent between 2002 and 2003, topping \$2,400 a year for family coverage, according to the Kaiser Family Foundation.

Another study by the Center for Studying Health System Change concluded that while employers can decrease annual premiums by 30 percent by switching to a high deductible with 20 percent co-payments, such a plan costs individuals with chronic illnesses \$3,000 a year in out-

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of-pocket costs, and that nearly one-third in that category would expend more than 10 percent of their annual income to cover their costs. This is a particularly ominous development, given that long-term illnesses such as diabetes are on the rise among Americans. More than 17 million have

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been diagnosed with diabetes, a condition that requires nearly 10 percent of all annual healthcare expenditures to treat. As a result of such trends, more individuals are being saddled with inordinate financial burdens in order to secure ongoing medical care.

Added to this is the current precarious economic situation. Since the beginning of the decade, millions of middle-class Americans have lost their jobs. Many people between jobs have taken benefit-free contract or freelance work to pay their bills. In 1999 – two years before the current economic downturn took hold – some 16 million Americans between the ages of 19 to 64 were already covered by individual healthcare insurance policies.

Although insurers have begun more aggressively marketing individual insurance products in the intervening years, most individual policies require underwriting of each individual, meaning all but the healthiest can be rejected for pre-existing conditions. Deductibles for some plans can reach \$10,000 or more. Only five states currently offer any laws protecting the right of individual policyholders not to be discriminated against based on their health history.

The New York Times reported on this state of affairs in November 2003, with an article headlined, “For Middle Class, Health Insurance Becomes A Luxury.” It notes that “The majority of the uninsured are...accountants...employees

New Calls For Reform

There has been a push for healthcare reform on the state and national levels. “We have seen the most activity since the Clinton proposal failed nationally,” said Jerry Flanagan, an advocate with the Foundation for Consumer and Taxpayer Rights. “Now, more than any other time in the past, voters are ready for universal care, either in the form of a single-payer system or the regulation of the healthcare industry

of small businesses, civil servants, single working mothers and those working part-time or on contract.” It also discussed in-depth the concept of “middle-class poverty” for those families paying monthly health insurance premiums of \$1,000 or more.

Although poorer individuals and families often have government-sponsored options for coverage, their situation also is

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becoming more dire. According to a recently released survey by the Kaiser Commission on Medicaid and the Uninsured, 49 states and the District of Columbia have implemented or plan to implement Medicaid cost containment measures during 2004, including strictures on drug costs; reducing or freezing payments to providers; reducing or restricting eligibility; and increasing co-payments. Partly as a result, Medicaid enrollment is projected to grow only 5.5 percent in 2004, its lowest rate in four

as a utility.” The Foundation has been pursuing the latter option in recent years.

Peter Lee, executive director of the Pacific Business Group on Health, agrees that there have been more calls for reform than in the recent past.

“The cost of the uninsured is driving up rates for the insured, and it is a vicious cycle. There is no doubt a growing insecurity among the insured that

years. However, the report’s authors note the economic climate in 2000 was far better than today’s, suggesting that the current strictures may be locking out those who need assistance.

Moreover, with \$20 billion in Medicaid fiscal relief from the Bush Administration slated to terminate in July, the situation is predicted to become even worse, particularly as sluggish state tax revenue growth is not expected to offset budget gaps. The Kaiser survey noted that a state contributing 50 percent of the cost to its Medicaid facing a moderate 8 percent growth in expenditures could face a nearly 15 percent funding gap in 2005.

“We know that 2003 and 2004 were two of the worst years financially for state Medicaid programs since its inception nearly 40 years ago, and 2005 could be just as bad from the states’ perspective,” says Vern Smith, a principal at Health Management Associates and co-author of the survey.

The pressures on healthcare delivery have borne themselves out in a variety of ways. In Southern California, transportation and supermarket employees struck in October 2003 over proposed reductions of their health benefits. Although the transportation strike was settled quickly, 70,000 supermarket workers remained off the job as of February. Thousands of Teamster Union members who initially picketed in sympathy returned to work when they risked losing their own healthcare benefits.

is driving this trend,” he said.

Health care and the financing mechanisms to guarantee it for all Americans have been a major political issue since World War II, when the combination of a tight labor market and wage controls pressured employers to offer healthcare benefits in lieu of extra pay in order to attract workers.

Within a year of the war’s end,

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Harry S. Truman became the first in a line of mostly Democratic presidents to propose universal healthcare coverage. Truman's plan – which would have been financed by deductions from employee paychecks – was swiftly defeated by a Republican-controlled Congress.

Truman's successors have continued in a similar vein of futility. Although President Lyndon Johnson succeeded in establishing the Medicare program in 1965, health care at that time was a vastly simpler mechanism from both a financial and technological standpoint, and life expectancies were a decade shorter than they are now. Most healthcare resources are now allocated to either catastrophic care or to patients in the last months of their lives – practices that tend to drive up costs in much higher proportion to the returns they reap.

The last major proposal for universal healthcare coverage was made during the first term of the Clinton Administration. That plan, which would have enlisted private payers to provide coverage in a format known as “managed competition,” was roundly criticized by opponents as top-heavy. After its defeat in 1994, President Bill Clinton shifted his priorities to other domestic issues.

However, the pressure facing millions of Americans about how to obtain quality health care has, as Flanagan and Lee note, pushed the issue back to the political forefront. The dramatic expansion of healthcare coverage has been a focal point for the race for politicians vying for the Democratic Party's 2004 presidential nominee.

The candidates' proposals are a mixture of the traditional Democratic outreach to working and middle-class voters, blended with the party's relatively new approach of fiscal probity. Although most of the candidates have proposed allowing uninsured Americans to enroll in the same benefits programs available to

federal employees, they are also stressing components they claim would decrease healthcare delivery inefficiencies and enhance preventative care, eventually saving money.

Although they all fall well short of endorsing the politically dangerous single-payer system, each Democratic candidate has a significant plank in their platform calling for an extension of healthcare coverage to tens of millions of Americans. Their proposals include expansion of the Medicaid program; enrolling individuals in benefit programs enjoyed by federal

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employees; granting generous tax credits to help individuals and families purchase health insurance; increased funding for community clinics; reform of the U.S. pharmaceutical industry; and the installation of in-depth disease management programs.

Two of the candidates, retired general Wesley Clark (who recently withdrew from the race) and North Carolina Sen. John Edwards, are also touting proposals that would penalize parents if they fail to provide healthcare coverage to their children. Former Vermont Governor Howard Dean would require employers to pay two months of premiums to continue coverage for recently departed workers, and

would have the federal government pay 70 percent of the premiums for any employee who elects to continue coverage through the COBRA program.

Sen. John Kerry, the front-runner for the Democratic nomination, has proposed a rebate pool for treatment where costs would exceed \$50,000 per individual. Insurers would be eligible to receive 75 percent of the costs back. Kerry estimates this would save a typical family about \$1,000 per year.

While Sen. John Edwards' plan is designed to extend coverage to 21 million uninsured Americans at a cost of \$53 billion per year, it is also projected to save the healthcare industry \$17 billion a year by streamlining the processing of medical records, raising the bar for malpractice lawsuits and hiring 100,000 new nurses. Clark's proposals, which are along similar lines, were projected to save \$125 billion over 10 years. Kerry's proposals purport to save \$150 billion over the same period of time.

Even non-candidate Democrats are issuing reform proposals. Kerry's colleague from the Massachusetts delegation, Sen. Edward M. Kennedy, recently unveiled the Health Security and Affordability Act. If enacted into law, the legislation would require employers to spend no more than 12 percent of their payroll to provide healthcare coverage for workers. Like many of the presidential candidates, Kennedy proposes enrolling the uninsured into the same benefits program currently available to federal employees. Premiums would be on a sliding scale, based on the ability to pay.

Peter Lee of PBGH noted that the proposals – from the Democrats and incumbent Republicans – are indicative of how attitudes toward undertaking major healthcare reform have changed. “I've looked at the plans briefly, and I'm heartened at the number of Democratic

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candidates, as well as the Bush Administration, who have acknowledged that a change of some sort must take place,” he said. The Democrats also showed maturity about the issue by not proposing single-payer or universal care systems that would require massive overhauls of the existing systems, Lee added.

Although the Bush Administration also has pledged to help cover the uninsured, its proposals are far less ambitious than those of the Democratic candidates (for example, U.S. Health and Human Services Secretary Tommy Thompson calls for covering fewer than 5 million Americans).

The Bush Administration has also backed some distance away from its initial proposals. Its proposed fiscal 2005 budget calls for spending \$72 billion on the uninsured over the next decade – a significant reduction from the \$89 billion it had previously proposed. Of the healthcare reforms the Bush Administration has introduced, most have been strongly criticized by opponents. The recently enacted prescription drug benefit for Medicare beneficiaries – which would subsidize prescription pharmaceuticals for seniors and encourage private insurers to provide competing benefits – has drawn fire for the “doughnut hole” gap presumed to leave millions on the hook for drug bills that could reach thousands of dollars per individual prior to a second tier of coverage taking effect. When the Bush Administration recently unveiled its 2005

budget, it also disclosed that the drug plan is expected to cost some \$540 billion over 10 years – \$144 billion more than previously estimated. The projected cost overruns, when combined with an annual federal budget deficit topping \$500 billion, cast some doubt on the program’s long-term efficacy.

Another recently enacted Bush

Another recently enacted Bush Administration initiative, Health Savings Accounts, is intended to defray some of the costs non-Medicare enrollees incur from healthcare policies with high deductibles. Like Individual Retirement Accounts, contributions to HSAs are tax deductible and the income earned from investments grows tax-free.

Administration initiative, Health Savings Accounts, is intended to defray some of the costs non-Medicare enrollees incur from healthcare policies with high deductibles. Like Individual Retirement Accounts, contributions to HSAs are tax deductible and the income earned from investments grows tax-free. Withdrawals are used to meet expenses that might be incurred due to a catastrophic incident. Participants can contribute up to 100 percent of their health plan deductible annually, capped at \$2,600 for self-insured policies and \$5,150 for

family policies. Participants age 55 to 65 are allowed to make additional “catch-up” contributions of \$1,000 per year. Withdrawals that aren’t used for medical expenses are subject to income tax, plus a 15 percent penalty.

Families USA has criticized HSAs for their inability to provide protection to low-income individuals and families facing large out-of-pocket healthcare costs. It also suggested that the system would be exploited by healthier participants, eventually leading to higher overall healthcare costs.

According to a Families USA brief issued in July 2003: “The...plans...are likely to siphon off healthier people who anticipate few medical treatment costs and hope to shelter some income from taxes in the account. The people who can’t afford to put cash into an HSA will stay in insurance plans with a smaller deductible and lower co-payments. So will people who have health problems...this type of ‘cherry-picking’ (of) healthy people will make insurance...plans with smaller deductibles and low co-payments extremely expensive, leading more and more employers to drop this kind of coverage.”

Lee of PBGH disagrees with the concerns of Families USA, noting that there are no disincentives to the chronically ill from using such accounts. However, he does have concerns about such accounts when they’re not anchored to individual incentives. “Personally, I’m agnostic about health savings accounts that are not linked to consumer tools and financial incentives to promote preventative care and help the chronically ill,” he said.

What Other States Are Doing

Many states have taken the initiative to launch universal healthcare proposals of their own.

Maine, which has been on the forefront of the universal care movement, introduced its initiative, the Dirigo Health System, in May 2003 (Dirigo, Maine’s

motto, is Latin for “I lead”). Despite its relatively small population, Maine appears a microcosm for what ails the rest of the country: 96 percent of its uninsured work; 27 percent are self-employed; and 20 percent are eligible for coverage through their jobs but can’t afford the premiums.

Individuals who purchase their own insurance have a median deductible of more than \$4,000 per year.

Dirigo, which is expected to be operational this July with a preliminary enrollment of 31,000, promises to insure

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individuals whose income is at or below 300 percent of the poverty level (\$55,000 for a family of four and \$27,000 for an individual). Small businesses would be required to enroll 75 percent of employees, and pay up to 60 percent of the premium.

Partially financed by employer and employee contributions, Dirigo is expected to cost up to \$53 million in its first year of operation. Like the Democratic proposals, its backers claim the new system will save up to \$275 million on uncompensated care expenditures. Payers and providers will also be asked to cap their cost growth to 3 percent and operating margins to 3.5 percent.

Even though Dirigo has yet to become operational, Maine Gov. John E. Baldacci has claimed success in reining in insurance premiums. Preferred provider organization rate increases dropped by 33 percent last year compared to 2002, while HMO increases were down 20 percent. "This mirrors...recent reports from hospitals and the healthcare industry is taking Dirigo seriously," Baldacci said.

In Maryland, nearly 700,000 individuals lack health insurance – about 17 percent of the state's population. Fifty-nine percent of the state's uninsured earn above 200 percent of the Federal Poverty Level (\$36,800 for a family of four).

An organization called The Maryland Citizens' Health Initiative has proposed the creation of MdCare, a quasi-public insurer that would provide coverage for low to moderate income households. Families earning up to \$30,520 a year would obtain free coverage. Those earning up to \$53,410 would pay a premium ranging from 1.5 percent to 2.5 percent of annual income. All income bars for entry into the Maryland Children's Health Insurance Program would be lifted. Individual coverage would be governed by the same rules for small group coverage, elimi-

nating many underwriting restrictions.

The plan would be financed by a 4.5 percent payroll tax on Maryland businesses for salaries up to \$87,000, with an additional 3.5 percent surcharge on businesses employing more than 10,000 workers. Those taxes would be credited back up to 100 percent, depending on the amount of money businesses spend to cover their employees. Higher income individuals who decline to seek health insurance would pay a tax penalty of up to \$2,600 a year.

(Sen. Shiela) Kuehl's legislation, SB 921, titled the "Healthcare for all Californians Act," passed the Senate in June and is now under consideration in the Assembly. The bill would streamline private payer claims into a single electronic system; authorize the state to conduct bulk purchasing of pharmaceuticals and durable medical equipment; and provide every resident access to a primary care physician.

An analysis of the Maryland plan by the Lewin Group concludes it would cost about \$665 million a year to enact. According to the Maryland Healthcare Commission, private and public providers currently spend up to \$3.7 billion a year to treat the uninsured. As a result of the estimated cost savings, the plan is receiving increasing support among state lawmakers, several of whom have promised to sponsor such a plan in the next session of the Legislature.

It remains to be seen whether such reforms would work in a much larger, densely populated and politically

fractured state such as California, whose number of uninsured is 10 times that of Maryland.

Two major pieces of legislation introduced in recent months address the issue. SB 2, which mandates firms with 20 or more employees insure their workers, was signed into law last year by former Gov. Gray Davis, but now faces a possible repeal. And Sen. Sheila Kuehl (D-W. Los Angeles), has proposed a single-payer system to be implemented by 2006.

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"It's time for California to address the gross waste and inefficiency that characterizes our current health system," Kuehl said. "We spend more than twice as much on health care as any industrialized nation, but have millions of uninsured and...much less coverage."

A study by the Lewin Group of a single-payer system similar to that proposed by Kuehl estimates it would save the state about \$7.6 billion a year. Lewin is currently assessing Kuehl's plan specifically.

Whether Kuehl's bill is likely to survive a vote in the Assembly and still be signed by Gov. Schwarzenegger remains to be seen. Many of the provisions are likely to disturb providers, including the creation of the Office of Medical Practice Standards and an Office of Inspector General for the state's entire healthcare system – agencies that are likely to duplicate the work currently performed by other state and federal regulators.

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Jerry Flanagan of the Foundation for Taxpayer and Consumer Rights doubted the bill in its present form would reach Gov. Schwarzenegger's desk, much less be signed into law. Among the reasons for this, Flanagan cites Schwarzenegger's current opposition to SB 2. Schwarzenegger and his supporters recently succeeded in putting SB 2 onto a ballot initiative, which means repeal if defeated by voters. "Compared to the Kuehl bill, SB 2 is a minor step," Flanagan said.

Flanagan also believes public support for SB 921 would be uneven at best. "It's one of the big concerns with the Kuehl bill, to construct a vastly different

system in one fell swoop. There's a morass of issues (involved)."

California Insurance Commissioner John Garamendi has also suggested a pilot program that integrates regular healthcare coverage with workers' compensation insurance as part of his recently unveiled workers' comp reform package. Garamendi's overall proposal has already garnered resistance from the state's Democratic lawmakers, and it remains unclear what the final disposition of the proposal will be.

Peter Lee of PBGH believes the proposed solutions, in many ways, ignore the more critical aspects of guaranteeing healthcare delivery. "To my mind, the single-payer, pay-or-play or individual

mandates are all moving deck chairs, even though they're big deck chairs. The real issue is, how are we going to get to understanding the major differences in healthcare quality across the delivery system?" he asked.

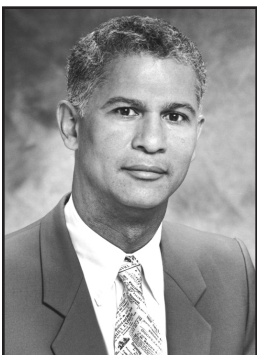
Lee also advocates some caution in moving ahead with reforms. "As much as we need to transform health care, there are many moving parts that affect one another, and we are better off having multiple significant steps rather than one giant leap...there are political concerns, economic concerns, and trying to change in one sweeping action payment designs for a system that comprises 15 percent of the U.S. economy, there are huge risks for unintended negative consequences," he said.

Conclusions

Given the current trends in healthcare coverage, both California and the nation are in a crisis that continues to become more dire each year. Taking into account the current political situation in California and nationwide, it is unlikely that a single-payer, Canadian-style system of health care will become the foundation

of a reform movement. Instead, changes will have to be incremental, and are more likely to occur on the state level. They will involve expanding Medicaid and Children's Health Insurance Programs to cover more uninsured, and a series of tax credits and incentives for individuals to purchase insurance and businesses to

provide it to their workers. Even enactments of those changes are expected to face considerable political opposition, and will have to be presented in a way that demonstrates they save money in the long run, rather than consume more revenues as an expansion of existing government programs.



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Jim Lott is a senior vice president with the Hospital Association of Southern California, where he is responsible for the management of policy development and advocacy for hospitals and integrated health care delivery systems in Los Angeles, Orange, San Bernardino, Riverside, Santa Barbara, and Ventura counties. He teaches health care policy and administration courses at three universities in Los Angeles and Orange counties.