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The American Health Insurance System: What Went Wrong and How We May Fix It

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by

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My goal with this paper was to look at the American health insurance system without conducting my own new research but instead using existing research to teach myself about an issue that will affect me both professionally and as an American citizen and taxpayer. To better understand the system today, Chapter 1 contains a discussion of the evolution in the last one hundred years, with health insurance going from near nonexistence to the burgeoning system we have today in both the private and public sectors. There is a consensus that the system is broken, but I wanted to further investigate what exactly is wrong with the system. Chapter 2 explores the issue by looking at access to care and the uninsured; the high costs of the American system to the government, businesses, and individuals; and how some financial issues affect quality of care. Chapter 3 explores proposed solutions as I draw my own conclusions on what I would like to see in healthcare reform.

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Chapter 1: The Evolution of American Health Insurance

Before focusing on the primary subject of health care finance in the United States, it is important to note that in the first half of the 20th century medical technology was viewed as nonessential, and medical care was not expensive enough to pose a threat of catastrophic loss; thus, Americans had little concern for health insurance (Hall, 1994). Rapid changes in medical technology and free flowing money into the health care system in the first half of the 20th century contributed to shaping the modern system's financing. However, before any discussion of where health care will go in the future there must be a basic acknowledgment of the system's development. It is best to view the evolution of American health insurance as it parallels the transition from small, private charitable hospitals that existed in the early 1900s to the exponential growth of these institutions as a hub of medical technology. While costs will be discussed in more detail in the chapter two of this paper, this chapter does include proposed solutions that have failed, from the Wagner-Murray-Dingell bill of the 1940s to the Health Security Act of the 1990s. Modern solutions will be explored in the final part of this paper. Reading this history, it is interesting to note moments and arguments in history that parallel arguments used today's debate over the government's role in health insurance.

Through the 1920s

Up until the late 1800s, the hospital as we know it today did not exist. There were no state health departments, and programs for communicable disease control and environmental sanitation were handled by local governments, to whom the federal government deferred. It was

not until 1869 that the first state health board was established in Massachusetts (Anderson, 1990). The United States only took responsibility for the treatment of merchant seaman and the armed forces (Litman and Robins, 1984). The government – federal, state, county, and municipal – contributed only about 20% of the total health care costs, leaving the bulk of the United States medical system financing to the private sector. Therefore, other than establishing a few bare standards and issuing medical licenses, the government's role through the first part of the 1920s was minimal.

In the private sector, the ill were treated in their homes and physicians' offices, and the underprivileged sought care in poorhouses. Physicians treated patients not necessarily seeking profit but out of concern; they very often worked voluntarily but ultimately made their living helping patients for fees and the "fee-for-service" system was born and entrenched in healthcare. The majority of the costs were covered by private sources including religious, fraternal, propriety, and community groups. Concerning the health care system in the early 1900s, University of Chicago sociologist Odin Anderson (1975) writes:

> The American hospitals were subsidized without interest or thought of repayment by the newly rich, and by contributions from the not-so-rich, in community after community across the nation…the American health service delivery system became a private system, both as to ownership of facilities and the provision of skills-- the voluntary hospital and the physician in private practice. No other country has been able to support as expensive and as socially

necessary a service from a large middle income group, because the mass purchasing power was not present elsewhere.

The system of private hospitals run by voluntary community boards and churches grew from a few hundred hospitals in 1875 to over 4,000 by 1900 (Anderson, 1990). With the growth of these mostly private institutions, the hospitals allowed physicians to run their private practices in return for servicing the destitute.

Patients continued to pay out of pocket or through barter and there was no need for health insurance. The general perception during this period was that medicine was ineffective; however, beginning in the late 19th century, medical advancements grew exponentially. Discoveries such as antibiotics and anesthesia led physicians to better prevent, cure, and manage health. As a result, the public's perception of a need for health care changed in the early 20th century from a passive or indifferent view of medicine to an assertion for a moral claim to medical care. The government encouraged the growth of hospitals by designating them as tax-exempt enterprises and making capital gifts to hospitals tax-exempt and interest free (Anderson, 1990). The expanding hospital systems increased research and technology to a point that hospital fees began to become a greater expense.

The major ripple of this period was when the 1914 American Association for Labor Legislation was drafted to provide workers with free medical care, paid sick leave, and a death benefit (Daschle, 2008). While the AALL bill had been introduced in some states, physicians and existing insurance companies battled it fearing government regulation of doctors' fees and the death benefit; by 1918, the bill had been defeated. It was not until the 1921 Sheppard-

Towner Act on Maternity and Infancy that the modern form of health care financing began to materialize. The act created the first continuous program for grants-in-aid to health state agencies for the service of individuals (Litman and Robins, 1984). Post Great Depression in the 1930s, more of the characteristics of the health care system financing had begun to change as a result of the loss of middle class affluence and the laissez-faire economics of the early 20th century falling out of favor in the United States.

1930s-1950s

The 1930s were marked universally by the Great Depression. When income fell across the board, support of almshouses that supported the poor declined and all hospitals sought means to keep a steady flow of funds to continue providing health services for the community. The great idea of insuring against health costs had begun to take root. Hospitals began to benefit from the payments upfront from their new "Blue Cross" plans for hospital coverage. The first of these plans was offered at Baylor University in 1929; the plans corrected for moral hazard problems by charging deductibles and copayments and limiting benefits to a specified number of days or a total amount of reimbursement (Hall, 1994). Soon, "Blue Shield" sponsored by state medical societies allowed for prepayment for physicians' services. The wild success of the Blue Cross and Blue Shield plans naturally led private insurance companies to enter the market. One problem the Blues began facing in the 1940s was that they were nonprofit and offered the same coverage for the same price to everyone (known as "community rated") and competed against for-profit insurance companies that would insure the younger and healthier for less than the Blues, effectively undercutting them. The Blues suffered from adverse selection covering older

and riskier Americans.

Changes in tax laws after World War II gave birth to the idea of company sponsored health insurance plans. First, fringe benefits were exempt from postwar wage and price controls. Second, these fringe benefits were excluded from personal income taxes. Eventually, a system evolved that allowed companies to purchase the employee's health insurance in lieu of the employee seeking coverage on his own. The benefit to companies was that they were able to hire employees at lower wages. From here, health insurance grew faster so that by 1952, over half of Americans had some form of health insurance (Anderson, 1990). With insurance companies now covering more groups, larger groups were assessed more accurately and at lower administrative costs, leading to decreased costs for groups as compared to individuals. By 1950, General Motors offered to pay for health insurance and pensions for all its workers; soon thereafter large American firms like U.S. Steel, Alcoa, DuPont, and AT&T followed suit (Daschle, 2008). In smaller industries, such as housing construction, unions negotiated industry-wide plans. From 1946 to 1957, workers with health insurance would increase from one million to 12 million, with more than 20 million dependents also included (Litchtenstein, 1995).

On the public side, President Franklin Roosevelt used the Preamble to the Constitution, "to promote the general welfare," to implement the New Deal and change public policy in regard to many issues, including medical care. In 1934 Harvey Cushing, M.D., one of America's most respected men in medicine, was appointed to the new Committee on Economic Security, which drafted what would become the Social Security Act. America's doctors worried how any proposed legislation would change the health care system; Cushing would become medicine's

advocate. The attitude of Cushing and doctors in the 1930s is not unlike that of doctors and patients today; he noted how "most of the agitation regarding the high cost of medical care has been voiced by public health officials and members of foundations, most of whom do not have a medical degree, much less first-hand experience with what the practice of medicine and the relation of doctor to the patient means" (Fishbein, 1947). This is a common criticism of the health care system and will be revisited later when looking at how this point of view is especially prevalent with health insurance providers and their determination of reimbursable medical procedures. Cushing used an indirect line of communication to President Roosevelt, as Roosevelt's oldest son James was married to Cushing's daughter, Betsey. Cushing was able to make sure that changes to the health care system would be acceptable to the powerful American Medical Association (AMA).

William Cohen, a staff employee on the Committee of Economic Security who would eventually become Secretary of the U.S. Department of Health, Education, and Welfare in 1968, wrote that today's national health insurance system was not envisioned in the Social Security Act of 1935. Campion (1984) writes that President Roosevelt proposed only modest changes that included "provisions for child and maternal health and assistance for the blind and for crippled children – measures the AMA could and did accept." In an interview with Campion, Cohen said, "President Roosevelt already had so damn much in the social security bill – social security and unemployment insurance – that he was opposed to any additional health insurance provisions in it." Therefore, while some changes in the health care system in 1935 were viewed as necessary, radical changes were not proposed because, as far as Roosevelt was concerned, it was not wise to

make changes that would breed strong opposition and risk having the entire Social Security Act voted down. There were more important issues in the bill that Roosevelt wanted to push through legislation quickly. Over the next ten years Roosevelt was never able to push for specific health insurance legislation because of resistance from Southern Democrats and Northern Republicans.

Odin Anderson (1975) recounts that "unless one was an adult during the 1940s, it is difficult to believe the polemical battles between the proponents of voluntary health insurance and government health insurance." While this may have been true when written, times have changed and the debate has ensued, as will be discussed later in this paper. It is clear that in 1945, health care financing was very much a controversial subject. Except in charity cases and for those with group health insurance, itself in its infancy, a patient's family was responsible for paying physician and hospital bills. At the time it was not a function of the government to subsidize health care, and political groups fought any proposal to fund states to expand medical coverage.

There were some attempts to expand healthcare financing. Democrat Senator Robert F. Wagner of New York proposed legislation in 1939 to authorize federal grants to the states to develop programs and expand medical service. While Wagner's proposal was rejected, the seeds of ideas had been planted effectively. Wagner and Senators Murray and Dingell proposed the Wagner-Murray-Dingell Bill in 1943 to expand the Social Security Act to include more for healthcare. There was initially no action on the bill. In 1944 when the United States was feeling the crunch from the Second World War, Roosevelt sought to raise the country's morale and give people a reason to sacrifice. Roosevelt promised a Second Bill of Rights that would guarantee

the rights to a job, to an education, and to medical care (Campion, 1984). After Roosevelt's death in 1945, postwar liberals worked to push a national health insurance bill after a stronger Republic party gained control of Congress in 1946. On November 19, 1945, President Truman gave Congress the first speech by any president exclusively on the subject of health, in which he outlined five points (Campion, 1984), including compulsory national health insurance, which the house called socialized medicine. The postwar liberals brought back the Wagner-Murray-Dingell Bill and a political battle ensued with organized labor, the National Farmers Union, supporting the bill and the AMA and organizations like the Blues opposing it. While in 1942 a *Fortune* magazine poll showed 74% of Americans supported government health insurance, a post-war media blitz successfully convinced Americans to encourage their legislatures to vote against the bill, calling it "socialized medicine" and an "enslavement of the medical profession," arguments akin to those today against government plans to support health insurance (Corning, 1969). The plan worked and the bill did not make it from committee to the floor the few times it was proposed in the late 1940s and nationalized medicine took a backseat to foreign diplomacy issues as China fell to Communism and the Cold War was beginning with Russia. Furthermore, the plan was not seen as necessary with more than 60% of Americans covered by the early 1950s.

The partisan lines that argued over government health insurance in the United States did not exist during the same time period in Europe, where organized labor worked with politicians to secure health insurance for every citizen.

1960s

Although millions of Americans were covered by Blue Cross, Blue Shield, and private insurance companies, large segments of the population were left uninsured as insurance companies adjusted by choosing who they would cover. As the community rating model fell out of favor, these insurers used the experience rating model as the community rating model and catered to the working middle class, essentially leaving out the unemployed, the ill, the disabled, and the elderly who were charged to forgo insurance because of higher premiums. Furthermore, hospitals that cared for these segments were unprofitable. Efforts like the Kerr-Mills Act of 1960 to give states grants to pay for the elderly and poor were largely unsuccessful. When President Kennedy and then President Johnson supported covering the elderly and the poor, the AMA resorted to the same media tactics it used to defeat national insurance bills of the 1940s. However, this time public sentiment rested with the elderly and poor. To cover these segments, in 1965 Congress created the Medicare Act as a federal program for the aged and the Medicaid Act as a joint federal-state program for the poor. The government paid 50% of hospital costs and 20% of physicians' costs. This program paved the way for cost increases as the government did not monitor costs and allowed providers to charge as they wanted. Furthermore, the American Hospital Association and Blue Cross lobbied Congress adopt a reimbursement formula of all allowable expenses plus a 2% bonus above costs (with no limit) to cover expenses (Daschle, 2008). As a result, from 1950 to 1965 expenditures as a percentage of GDP increased from 4.6 to 5.9 and per capita expenditures increased from $78 to $198 with no built in cost controls (Anderson, 1990).

1970s-1980s

In the 1970s, with the passage of bills like the National Planning Resources Development Act, the debate as to whether the federal government had a role in interfering with the private sector had begun to dampen as attitudes prevailed that it was becoming inevitable that some form of national health insurance would be created. President Nixon proposed the National Health Insurance Partnership Act that would have preserved private insurance but would require employers to either cover workers or contribute to a national fund to cover the uninsured. While there was some support from business leaders, the AFL-CIO, AMA, and National Federation of Independent Business were against it. After Watergate, President Ford could not garner enough support in face of the public's distrust in government and dissatisfaction with initiatives to rationalize the health planning process because of "rising costs, economic stagflation, limited revenues, diminished financial resources, programmatic cut-backs, indifferent and sometimes hostile central administrations, and the public's insensitivity toward the infringement of federal policies, directives, and regulations on state and local prerogatives" (Litman and Robins, 1984) in the late 1970s. Daschle (2008) describes President Carter's two attempts to reform healthcare. The first would have capped hospital charge increases at one-and-a-half times the consumer price index increase with a 9% ceiling; the second was a plan to cover everyone while keeping the private insurance intact. The first plan failed after vehement opposition from hospital and business special interest groups, and the second plan failed after support was lost when Carter cleaned his cabinet in 1979.

Upon Ronald Reagan's inauguration in 1980, he immediately ordered budget cuts to follow through on campaign promises to reverse the direction of federal expansion begun in the Roosevelt Administration. Barry Rabe (1987) writes that Reagan's plan to defederalize health care in the United States followed these ideas: *decentralization*, i.e., the transfer of authority to the states by dismantling of existing federal categorical programs and consolidation of others into block grants; *deregulation*, through the abolition or weakening of regulations, appointment to leadership positions of individuals who were opposed or unsympathetic to the basic mission or purpose of certain bureaus or agencies, as well as a reduction in funding; and *redistribution*, i.e. proposed reductions in or elimination of direct forms of government assistance to individuals through entitlement programs, such as Medicare. These efforts were not enough to curb increasing costs, as health spending increased from 8.9% of the GDP in 1980 to 13.6% in 1993 (Enthoven, 1999).

In the private sector, the idea of managed care evolved in the 1980s to restrict users to an approved network of providers and required the use of a new third party, a managed care firm, to coordinate care and financing (Daschle, 2008). Providers in the network benefited from a constant stream of patients, knowing few patients would venture outside the network with higher copayment costs to those who did. These Health Maintenance Organizations (HMOs) first appeared to be a cure as enrollment grew from 9.1 million in the mid-1980s to 36.5 million by 1990 (Daschle, 2008).

1990s

In the private sector, backlash began against managed care as Americans complained about the third parties having too much control over deciding what treatments and procedures a doctor could use and what specialists (if any) a patient could see. Doctors felt they had lost control of their patients' care to the hands of people with no medical knowledge or experience. While states passed laws to better protect the doctors' authority, physicians still debate with third party insurers over appropriate medical procedures and treatments.

By the early 1990s, health care reform had been put back in the national spotlight with conservatives supporting a market driven approach led with tax credits and vouchers for low-income families and liberals moving toward a new "managed competition" approach of pooling the power of businesses and individuals. President Clinton adopted this approach and promised "personal choice, private care, private insurance, private management, but a national system to put a lid on costs, to require insurance reforms, to facilitate partnerships between businesses, government, and healthcare providers" (Skocpol, 1997). Over the summer of 1993, there appeared to be a plan that both sides could agree upon, and President Clinton proposed his plan nationally in front of Congress on September 22, 1993. The Health Security Act would have covered all Americans by increasing taxes and requiring all employers to provide employees health insurance through tightly regulated and competitive HMOs. When the plan appeared to be inevitable, foreign diplomacy issues arose, including situations in Somalia and Russia, and temporarily delayed the bill's priority long enough for opponents to mobilize. Effective opposition through the media and decreased Democratic support in wake of the breadth and

complexity of the proposal, which was over 1300 pages long, led to the bill becoming stagnant and not even reaching a vote.

Conclusion:

The evolution of health insurance in the United States in the last one hundred years alongside marked improvements in medicine is remarkable. A century ago, the poor were supported in almshouses and charitable hospitals while the rich were cared for at home by physicians. The advancements in antibiotics, anesthesia, and other improved technologies led to more people seeking health care. When originally few insurance companies offered health insurance, the wild success of Blue Cross and Blue Shield plans brought more companies into the mix and increased competition, especially competition for the young and healthy. For the old and poor left out of the mix because of high premiums, Medicare and Medicaid came into existence. However, when the government began reimbursing providers for care, more parties sought a piece of the health care pie, and runaway costs have led to the broken system that we have today.

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Chapter II: Access, Quality, and Costs

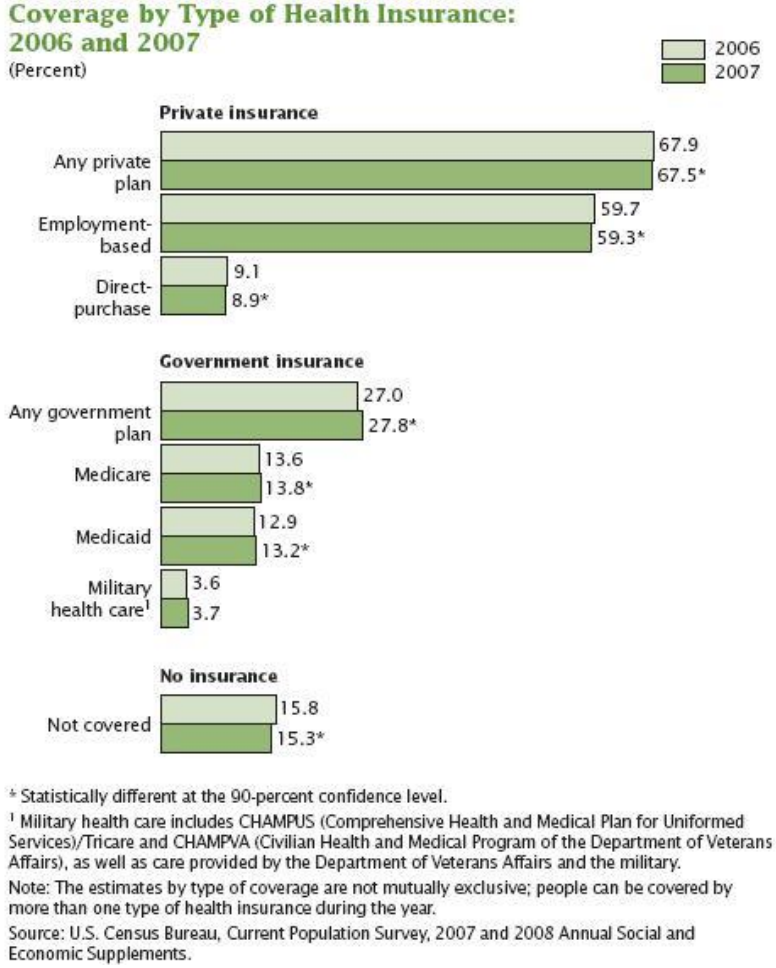
There are certainly links between the United States healthcare system and the economy, and fixing the healthcare system is important for the economy. Ben Bernanke said in June 2008 at the Senate Finance Committee Health Reform Summit that the "decisions we make about health-care reform will affect many aspects of our economy, including the pace of economic growth, wages and living standards, and government budgets, to name a few." While economic effects are an interesting study, they are out of the scope of this paper. The focus of this chapter is to investigate access to insurance and the uninsured, the effects on the quality of healthcare, rising healthcare costs, and the effect on the government, businesses, and individuals.

Access and the Uninsured:

According to a 2008 U.S. Census Bureau report, the number of insured Americans increased from 249.8 million to 253.4 million. While the number of people with private insurance remained unchanged at 202.0 million, the percentage decreased slightly from 67.9% to 67.5%. Of those with private insurance, the change in those who used an employer-based plan was statistically insignificant and remained at 177.4 million, but the percentage decreased from 59.7% to 59.3% as a function of increased population size. However, over the last 30 years, that 59.3% of those with employer-based plans has decreased from 70% in the 1970s. Daschle (2008) says this may be because of the increase in independent contractors, temporary employees, and part-time employees in the United States workforce who are not eligible for health benefits. The increase in insured Americans was largely due to the increase of government program insurance (Medicare, Medicaid, and military health care; the State

Children's Health Insurance Program (SCHIP); and individual state health plans); the number increased from 80.3 million to 83 million or from 27.0% to 27.8%. The results of type of health insurance coverage are summarized in the Figure 1, from the U.S. Census Bureau.

Figure 1



* Statistically different at the 90-percent confidence level.

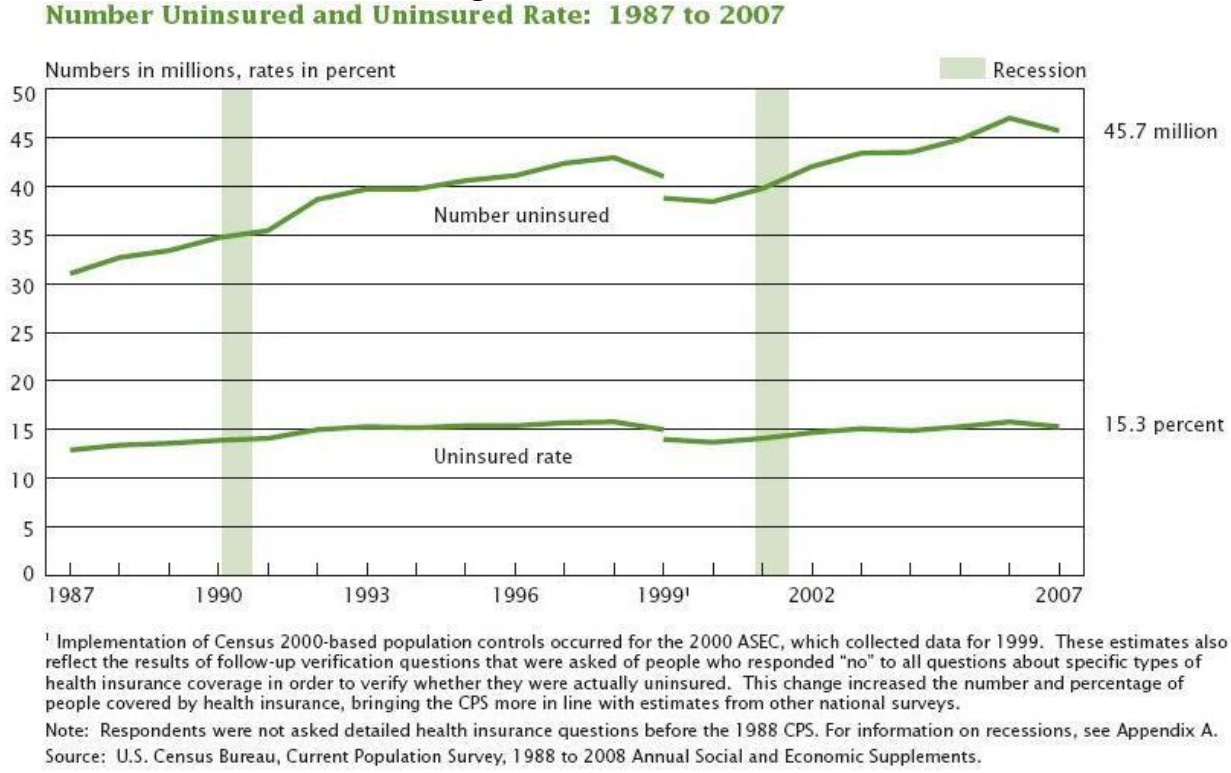
[1] Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs and the military.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2007 and 2008 Annual Social and Economic Supplements.

According to a 2008 U.S. Census Bureau report, from 2006 to 2007, the number of uninsured in the United States decreased from 15.8% to 15.3% or from 47.0 million to 45.7 million, but this is up from 38.4 million in 2000. Figure 2 shows both the number of uninsured and the rate on the uninsured in the United States since 1987. The slow increase in the rate during the early 1990s and then early 2000s reflect Americans' dissatisfaction with HMOs controlling networks of doctors (as discussed in Chapter 1), the increased cost of carrying health insurance (as will be discussed further in this chapter), and increased unemployment following economic recessions in the early 1990s and 2000s.

Figure 2



[1] Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions that were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.

Note: Respondents were not asked detailed health insurance questions before the 1988 CPS. For information on recessions, see Appendix A.

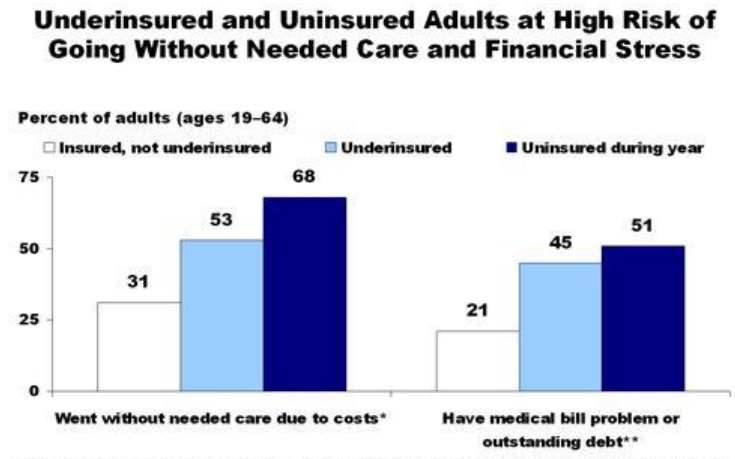
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2008 Annual Social and Economic Supplements.

It is important to understand some reasons why Americans are uninsured. As it is written now, Medicaid is for low-income children, parents, pregnant women, disabled persons, and the elderly, so most non-disabled adults under age 65 without dependent children are not eligible for Medicaid regardless of income. One reason that those not covered by government health insurance do not have any coverage is that their employers do not offer group health insurance, and these individuals cannot afford to buy insurance in the more expensive nongroup market. Unfortunately, the costs to businesses and individuals are increasing, resulting in companies decreasing or eliminating health benefits, thereby preventing individuals from getting the coverage they need (this will be explored in more detail later in the cost section of this chapter). A second reason is the aforementioned increase in temporary and part time workers that do not receive health insurance in groups and also must seek coverage in the nongroup market. Finally, there exists a segment of Americans that, for whatever individual reasons, choose not to enroll for federal assistance despite eligibility.

Looking closer at the uninsured, it follows logically that the majority of the uninsured have low incomes. A 2008 Kaiser Foundation study found that almost two-thirds of the uninsured are below 200% of the federal poverty line (about $40,000) and only one of ten is more than 400% above the poverty line. The conclusion is that those most sensitive to medical debt (those below the poverty line) are those that perhaps most need insurance to protect against financial ruin. Because the average annual cost of employer-sponsored family coverage in 2007 was $12,106, for those with lower income, a larger employer contribution is necessary.

One class of Americans often lost in discussion of health insurance is the underinsured. A 2008 Commonwealth Foundation study, led by Cathy Schoen, defined the underinsured as those spending 10% of income on out-of-pocket healthcare costs (or 5% if poor) or if they had deductibles equal to 5% or more of income. About 25 million were found to be underinsured; this is about 14% of nonelderly adults, and this figure is up 60% since 2003. The study found that the hardest hit in the time period was the middle class, with their underinsurance rate increasing three-fold since 2003. Combined, 42% of nonelderly adults, or 75 million Americans, are either underinsured or uninsured. Some of the uninsured and underinsured also have costly preexisting health conditions that make the right health insurance unaffordable. Without insurance many Americans will forgo seeing physicians because they cannot afford doctor visits and preventative care, as seen in Figure 3. Another significant 2008 report found that every year 20,000 uninsured Americans die from a lack of preventative care (Dorn, 2008).

Figure 3



http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Jun/How-Many-Are-Underinsured--Trends-Among-U-S--Adults--2003-and-2007.aspx

From a financial point of view, Figure 3 also shows how medical bills are a problem for both the uninsured and underinsured compared to the fully insured. Another study found that 23% of the uninsured reported having to borrow money to pay for medical bills, a rate twice that of the insured (Kaiser Family Foundation, 2008). With the majority of the uninsured being on the lower end of pay scales, they are less likely to have assets or income to repay debts that accumulate. Furthermore, 37% of the uninsured have been contacted in the last five years by a collection agency concerning medical bills, compared with 21% for the insured (Kaiser Family Foundation, 2008).

The effect of medical bill debt is, however, not limited only to the uninsured, but is a significant cause of concern for the insured. A second 2008 Commonwealth Fund study, led by Karen Davis, found that 47 million of the 79 million Americans who cannot pay their medical debts were insured at the time of the debt was incurred (Davis, 2008). The result has been that millions of Americans have filed for bankruptcy with their medical bills being a significant determinant; in fact, medical debt is the number one cause of bankruptcy in the United States (Himmelstein, 2005). In 1981, about 25,000 families filed for bankruptcy after a serious medical problem, and by 2001 about two million Americans sought protection in a medical bankruptcy (Himmelstein, 2005). Because medical bankruptcy rate increased 11% in the 18 months after the study, we can safely presume that medical bankruptcy is still an issue for millions of Americans.

Interestingly, Doyle's 2005 study even linked the quality of care to being uninsured. The study found that uninsured victims in automobile accidents received 20% less treatment in hospitals and are 37% more likely to die as a result of their injuries than those who are insured. Furthermore, the Institute of Medicine (2000) reported that uninsured people are less likely to receive preventive and screening services, less likely to receive appropriate care to manage chronic illnesses, and more likely to die prematurely from cancer – largely because they tend to be diagnosed when the disease is more advanced.

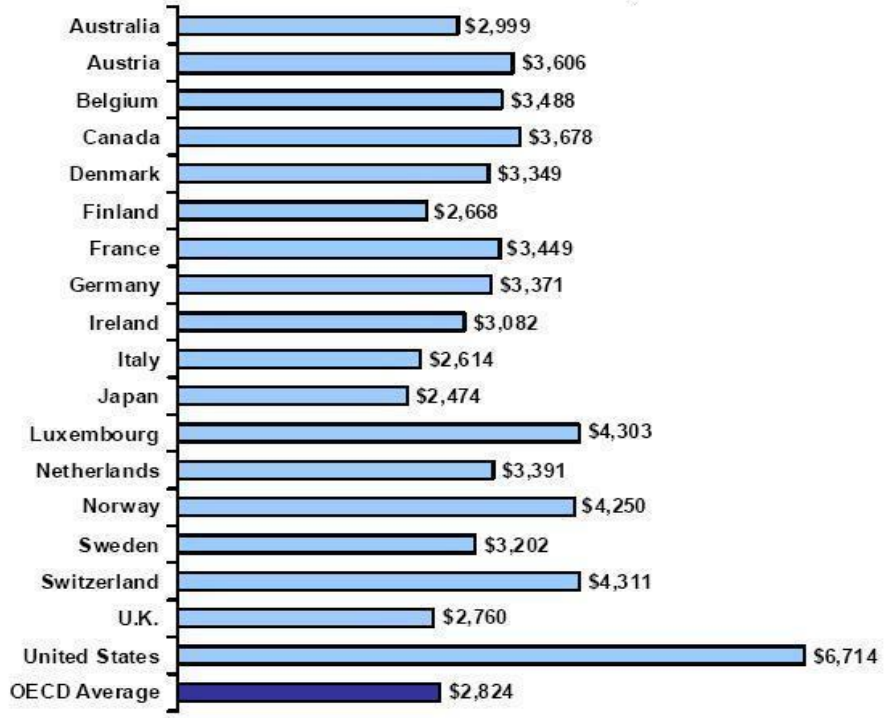
Quality:

Discussions on quality of healthcare for people of different race, gender, religion, etc., is not in the scope of this paper, nor are discussions on improved quality and economic effects, but a discussion on some quality issues related to finance are appropriate here, particularly on the importance of primary care physicians and how a few moments in history have pushed physicians away from primary care toward specialization.

One 2006 study that looked into Medicare expenditures per eligible recipient in different regions of the United States did not find that areas with greater expenditures had greater outcomes, and in some cases regions were outperformed by regions with lower expenditures (Skinner, Douglas, and Elliot, 2006). This suggests that some patients receive too much care; Bernanke (2008) says that quality could improve greatly just with increased use of "evidence-based medicine" and allowing physicians to use their medical knowledge to improve patients' outcomes.

Relative to other industrialized nations, the U.S. has a greater total health expenditure per capita, as illustrated in Figure 4. Expenditures are defined as "total consumption of healthcare goods and services plus capital investment in healthcare infrastructure, both public and private" (Khoury and Brown, 2009). While the United States has a far greater expenditure than other nations, it has not translated into favorable outcomes. The United States' Personal Health Index score, which demonstrates a nation's perception of its health, is a 78, a score that is average compared to other developed nations (Khoury and Brown, 2009). Thus, as was the case with Medicare expenditures not leading to greater outcomes, the higher U.S. health expenditures have not translated to greater outcomes.

Figure 4: Total Healthcare Expenditures Per Capita in OECD Nations



Amounts in U.S.D. Source: Organisation for Economic Co-operation and Development, *OECD Health Data 2008*, updated August 26, 2008. http://www.oecd.org/health/healthdata.

As will be discussed in more detail later, chronically ill patients are the biggest drain on health care finance. Several proposals emphasize the need for more primary care physicians to help manage a patient's health; however, it is becoming increasingly difficult to find physicians who want to go into primary care because of financial issues.

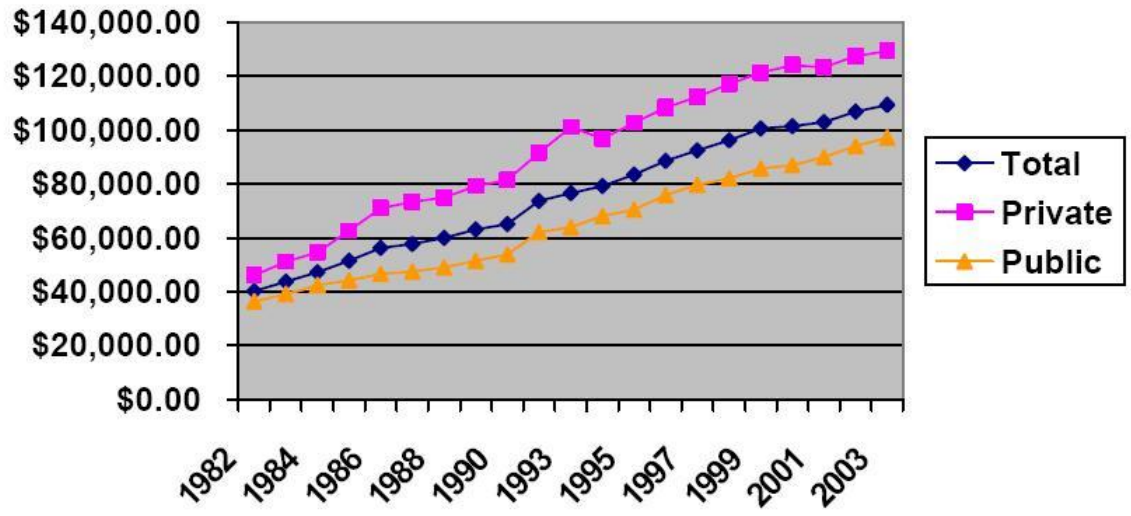
The history of the beginning of specialization in medicine is intriguing. During World War II when American medical school classes were sent to Army and Navy, they learned the importance of having credentials; namely, those that received specialty training were paid as a captain and those without specialty training were paid less on the level as first lieutenant. Campion (1984) notes how this pushed physicians to recognize a hierarchical structure in which those with specialty training were on the upper rungs. Part of the GI Bill of Rights passed by Congress in 1944 allowed for physicians to receive post-graduate medical education benefits, namely residency training upon their return home.

Another step that pushed physicians from primary care to specialization was Congress' establishment of the physician payment model in 1989. The Centers for Medicare and Medicaid Services is influenced by the recommendations of the American Medical Association's Relative Value Update Committee in determining the value of medical services provided by physicians and thus physician payment. The problem is that the services a primary care physician can code, or bill, for are very limited, and payment as compared to specialists is lower. Bodenheimer (2006) explains that 30 minutes spent performing a diagnostic, surgical, or imaging procedure often pays three times as much as a 30-minute visit with a patient with diabetes, heart failure, headache, and depression. Furthermore, the average salary of a specialist in 2004 was nearly

twice that of a primary care physician.

According to the Association of American Medical Colleges (2009), 87.6% of the medical class of 2007 graduated an average debt of $139,517; furthermore, 75.5% of graduates had debt greater than $100,000. Figure 5 illustrates in terms of 2003 dollars how medical education has steadily increased faster than inflation.

Figure 5: Medical School Student Debt Upon Graduation in 2003 Dollars



Medical student debt in 2003 dollars over the past 20 years. Student debt has continued to outpace inflation at slightly over 1% per year, with the trend showing no sign of leveling off.

Source: http://www.ama-assn.org/ama1/pub/upload/mm/15/debt_report.pdf

The combination of medical students graduating with more debt and specialty training paying greater salaries has resulted in a decrease in primary care physicians at a time when healthcare reform is calling for increases in primary care. This decrease is making it increasingly more difficult for people to make appointments, and those that do see physicians are rushed through to allow a greater number of people to seek help. Some studies find that half of

chronically ill patients leave the office having not understood what their physicians said (Roter, 1989). Without any changes, the number of primary care physicians will continue to decline and, thus, decrease the quality of health of Americans.

Costs:

In this section, I first investigate how costs have increased, from increased technology to increased malpractice insurance to increased fraud, and more. With an understanding of some drivers of costs, I will finish the section looking at some of the effects on the government to businesses and individuals.

In 1944, Congress passed the Public Health Service Act to support biomedical research outside of the Public Health Service and military and to expand the National Institutes of Health (NIH) (Fredickson, 1978). The result has been an exponential increase in medical research grants from the NIH, from $85,000 in 1945 to $2.5 billion in 1982 to $29.5 billion in 2008, with a trickle down effects of further pushing specialization and increasing the number of modern hospitals operating with modern equipment as centers for medical care (Nelson, 1978 and Day, 2008). Hospitals continue to add modern medical technology each year, and this increasingly more expensive technology has contributed to skyrocketing medical costs; it is estimated that between 38% and 65% of health care cost increases are driven by new technology (U.S. Census Bureau, 2007). However, it is important when discussing rising costs to remember that costs are not for the same level of care but for an increased level as a result of new technology every year. Bernanke pointed out a 2001 study by Cutler and McClellan which concluded that the health benefits of new technologies and other advances significantly exceed the economic costs of the

technologies. Thus, there are benefits to new technology and it is not a matter of providers trying to increase their revenues.

Despite the prevalence of high-tech medical equipment, the use of electronic records is sparse. Daschle (2008) estimates that only 15-20% of clinicians use electronic medical records. The errors resulting from a lack of use of electronic records costs the system about $78 billion a year (Walker et al., 2005). A 2000 Institute of Medicine study finds that 98,000 Americans die annually from medical errors unrelated to technology, such as bad handwriting and incomplete charts (Kohn et al., 2000). Financially, the study estimates that these errors cost about $29 billion annually.

Because of litigation losses, insurance companies have had to charge more for malpractice insurance for physicians; steadily, this is becoming more of a problem. With some insurance premiums prohibitive, some physicians have been forced to retire or move to practice in states with more favorable malpractice protection, decreasing healthcare quality with fewer physicians. Those physicians that do practice with high premiums often pass the charges on to insurance companies, which then pass the charges on to the insured in the form of higher premiums. Doctors are forced to try to protect themselves by ordering more tests than are often necessary or delay treatment; this practice of "defensive medicine" adds about $50 billion a year in total costs, with $28.6 to $47.5 billion of taxpayer money wasted on supporting this system (Joyce, 2007).

A prime example of wasteful spending is a 2009 WellPoint study which shows how much money goes toward treating back pain alone. Most back pains are eased within six weeks, so

national guidelines do not recommend expensive imaging tests and surgery within those six weeks unless "red flag" conditions exist (e.g., cancer, trauma, fractures, or progressive neurologic problems). The 2005 research found that about 35,000 of about 172,000 patients without these "red flags" received unnecessary imaging tests, and about 1,000 underwent surgery within six weeks of injury, leading to $23.6 million of treatment that may have been unnecessary. WellPoint chief medical officer Dr. Sam Nussbaum explains: "As Americans, we spend roughly as much on back problems as we do for cancer or diabetes with very little change in overall result…Most people will get better without having the risk, pain, and expense of surgery." This is the situation with back pain, but across health services money is spent unnecessarily.

The current healthcare system does nothing to encourage providers from reducing costs that are passed on to the insured and the federal government. Furthermore, with Medicare and Medicaid each using more than $400 billion a year, they have become targets of fraud. Healthcare fraud cost about $60 billion in 2005, and to cover the losses, higher premiums, copayments, and taxes were passed on to Americans (Blue Cross and Blue Shield, 2006). Under our fee-for-service system, providers bill the government, and it is generally assumed that the claims are legitimate; furthermore, most claims are highly automated and are not subject to human scrutiny (Sparrow, 2008). Medicare and Medicaid do not reimburse for every procedure or treatment, so a provider can cheat the system by correctly coding for a procedure not performed or one that is exaggerated. An example is coding for procedures not performed when a person undergoes a routine checkup, which is not covered by Medicare. There is a small

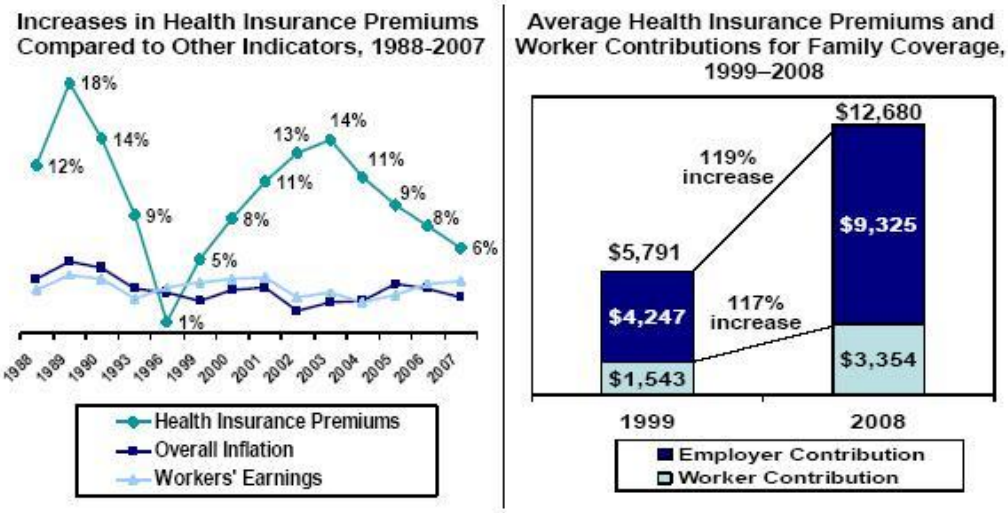
system that does check claims, but the physician can easily just write in his records that he or she did indeed perform the procedure. There also exists fraud from other sources, such as pharmaceutical companies, but that is out of the scope of this paper.

With an understanding of some of the drivers of costs, we can now study the effects of increased costs. The Congressional Budget Office (2008) has shown that the healthcare sector has grown on average 2.5 percentage points more a year than the GDP and at this growth rate, health spending would exceed 22% of the GDP by 2020 and reach almost 30% of GDP by 2030. Furthermore, the CBO says that in 1975, federal spending on Medicare and Medicaid was about 6% of non-interest federal spending, while today that figure is up to 33% and will grow to half of the federal non-interest outlays by 2050 if no changes are made. As of December 2008, the CBO projects that federal spending on Medicare and Medicaid will increase from 4% of GDP in 2009 to 6% in 2019 and 12% in 2050; this increase is not only a result of the increased elderly population but more of increased per capita costs. A further government problem in today's economy includes the fact that many states are struggling with deficits and are being forced to make budget cuts. The complex problem in these states is that they are cutting Medicaid funding at a time when more people are losing their jobs and becoming eligible for Medicaid. A 2008 Kaiser Family Foundation study entitled "Impact of Unemployment Growth on Medicaid and SCHIP and the Number Uninsured" reports that for every 1% increase in the national unemployment rate an additional one million people enroll in Medicaid, at a cost of $1.4 billion to states.

Healthcare spending is the single largest personal consumption expense, greater than even spending on either housing or food (Bernanke, 2008), but unlike housing or food, healthcare costs are unpredictable. One documented problem is how fast premiums are increasing compared to inflation and wages. A 2008 joint Kaiser Family Foundation and Health Research & Educational Trust report shows that between 1999 and 2008, premiums rose 117% for families and individuals and 119% for employers. This is illustrated in Figure 6, which also shows how health insurance premiums have increased faster than both inflation and worker earnings. The average premium for an individual in 2008 was $4,704, while that for a family was $12,680. Increases in premiums for individuals and families have led to both dropping of insurance or underinsuring, as previously discussed.

Figure 6

Illustrations of Health Insurance Premium Increases



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1988-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007.
from Fig 1.2, Call To Action: Health Care Reform 2009, Max Baucus

A Kaiser and HRET report also investigates businesses offering benefits. As mentioned before, many companies offer health benefits to attract workers. About 99% of large companies (defined as those with more than 200 workers) offered health benefits; this rate has been constant for about ten years. Meanwhile, 62% of small companies offered health insurance benefits, down from 68% in 2001. The 38% of small companies not offering health benefits cited high premiums (48%), small firm size (21%), and employees being covered elsewhere (19%) as the most common reasons. Covered workers contributed 16% for individual coverage and 27% for family coverage. Of these covered workers, the majority of the employers covered at least half of the premium.

Large companies, on the other hand, have had to work to maintain health coverage of employees, and the problem for these companies is controlling costs. Medical costs are unlike the many fixed costs a business encounters because health costs are absolutely unpredictable – the use of the system is unpredictable. During past economic recessions when margins were small, businesses had to rework their health insurance plans. After the recession in the early 1990s, businesses created larger discounts by limiting access with administrative controls and restricting provider choice. However, during the boom of the late 1990s, businesses loosened controls slightly at the request of employees. In response to the recession in the early 2000s, businesses decreased their costs by requiring higher deductibles as well as increasing copayments and coinsurance for employee-patients. Businesses do not see higher patient cost sharing as a viable long-term solution, so new solutions must be developed in face of the recession the United States is experiencing in 2009.

However, the idea of businesses trying to control health care costs is not limited to the last 15 years. For example, Daschle (2008) writes that when Lee Iacocca took over Chrysler in 1978, health care costs exceeded steel and rubber material costs by about $600 million; this added $600 to each vehicle. Iacocca investigated his company's costs and found that podiatrists worked on one toe per visit to maximize claim payments, while dermatologists unexpectedly were making more 25% more than chest surgeons and twice that of general practitioners, among other overcharges from physicians. Chrysler reacted by creating a health screening program and a "preferred provider" plan. These changes in the early 1980s only provided short term results, and industry wide, health care costs contributed to the financial woes of American auto makers. Ford and GM pay $1,500 in healthcare costs per vehicle while BMW pays $450 per vehicle and Honda $150 per vehicle. These costs are putting American auto companies at a disadvantage compared to their foreign competitors and have contributed to the April 2009 bankruptcy of Chrysler.

Conclusion:

In a 2009 NPR interview, Uwe Reinhardt, a professor of political economy at Princeton University, explains how the insurance system often times is irrational. He says that a hospital negotiates with different insurance companies on the costs of procedures, which results in the same procedure costing a different price depending on the insurance company. Furthermore, the hospital could be paid a different price by the same insurance company if the contract is an HMO, PPO, etc. In his research of New Jersey hospitals, Reinhardt was astounded by the range of prices, such as a hospital charging anywhere from $400 to $3000 for the same procedure. He

found that it is profitable for both the hospital and the insurance company to haggle reimbursement because each is trying to protect a bottom line. While it might be profitable for the hospital to hire negotiators, Reinhart says that doctors lose time in haggling with insurance companies over the necessity of a procedure or to eliminate preauthorization and that doctors essentially become the ombudsman between insurance companies and their patients. The problem is that physicians have less time to care for patients if they are spending more time haggling with insurance companies for authorization.

These are just some of the problems of our healthcare system that have lead to varying costs and levels of quality. With an increasing number of uninsured draining an already broken healthcare system and costs being passed on to the insured, now is the time to fix the health care system. However, as explained in the Reinhardt interview, there are many conflicts of interests in the system today, so finding a middle ground to control cost, insure more Americans, and increase quality of care is an enormous task.

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Chapter 3: Possible Solutions

Most healthcare reform solutions include the idea of moving from a "fee-for-service" system to a "pay-for-performance" system that emphasizes quality of care over quantity of care to improve value. With the cost of covering the uninsured shifted to those who do carry health insurance by increasing premiums, every proposal will also have some focus on decreasing the amount of the uninsured by emphasizing expansion of coverage and lowering costs, which consequently lowers premiums and allows for the uninsured to become insured.

One controversial idea that many plans involve is some form of universal coverage. If the United States required everyone to carry health insurance then, hypothetically, health insurance premiums growth will slow. Also, requiring all Americans to carry health insurance will support physicians' call for preventative medicine and care to manage chronic illnesses to promote wellness. The Centers for Disease Control and Prevention (2008) reports that about 45% of Americans have a chronic condition and chronic diseases account for 70% of deaths (2004). Additionally, a 2003 study by Mollica and Gillespie found that about 78% of U.S. healthcare spending is due to chronic illness. Therefore one idea behind mandating coverage is that increased wellness and a more efficient healthcare system will reduce medical costs and not only make health insurance affordable for individuals and families but also for employers to continue offering health care coverage to employees.

In this chapter I will explore some proposals to reform healthcare. There is no shortage of people and foundations with their own proposals, but with a Democratic President and Congress, if there is to be any reform in the next few years it will likely be in favor of liberal

proposals like those of Tom Daschle and Max Baucus. I will also look briefly at a conservative plan from the Health Care Freedom Coalition to compare and contrast it to liberal plans. Finally, I will end the chapter with some of my own thoughts on healthcare reform.

Daschle's Plan:

Considering that President Obama first appointed former Senator Tom Daschle to lead the White House's plan to reform health insurance, we can presume that Obama and Daschle think similarly about healthcare reform; therefore, a discussion of Daschle's plan in his book Critical: What We Can Do About the Health-Care Crisis is appropriate to understand where Obama has gotten some of his ideas.

Daschle notes that while Medicare, Medicaid, and the Veterans Health Administration provide care to about 100 million people, there exist different benefits, quality standards, and successes in cost containment. Daschle proposes a Federal Health Board to be modeled like the Federal Reserve Board. The Board would create a model of all insurance programs by establishing a single set of standards. Daschle makes the curious point that allowing Congress to set standards for varying insurance organizations is akin to letting Congress taking power from the Federal Reserve and setting and enacting interest rates itself each quarter. He specifically mentions the Massachusetts Commonwealth Health Insurance Connector Authority as a board that determines benefits insurance companies in the state must provide. He also uses Great Britain's National Institute for Health and Clinical Excellence as a single entity that provides guidance on use of drugs, treatments, and procedures. Decisions are recommended to Britain's National Health Service for implementation; Daschle's Board, on the other hand, would have

more autonomy. Finally, he also mentions the Swiss system, which requires insurers to meet standards set by its Federal Social Insurance Office; Swiss citizens are required to purchase, at minimum, the basic package.

Daschle argues against "employer mandated" insurance because it would be problematic to those who lose jobs, part-time workers, and the self-employed. Rather, he prefers to improve upon the system we have now that has 80% covered through employment-based plans. For the other 20%, Daschle recommends opening up plans like the Federal Employee Health Benefits Program (FEHBP) to more Americans. Small businesses pressured by the costs of premiums could simply allow their employees to purchase a FEHBP-type plan. Daschle argues that this government program would have great bargaining power to negotiate prices with providers and allow for lower costs and lower premiums. To help Americans pay, he suggests a refundable tax credit, which as mentioned before is another idea Obama has adopted.

Daschle's improving upon the current majority employment-based sponsored system while allowing a government plan creates what many call a "public-private hybrid." I believe that some hybrid is the best means to reform, although as recently as late March 2009, there are some complaints being raised by insurance companies, as will be mentioned with more detail with a discussion of Obama's plan next.

Obama and the Budget:

Since taking office, President Obama has devoted much time to correct the financial system and has had to deemphasize some of his campaign promises, including healthcare reform. Still, Obama has eight principles and goals when looking at possible health care reform plans.

The 2010 budget lists Obama's promises to *protect financial health* of families and businesses by reducing growing premiums; to *make coverage affordable* by reducing administrative costs, unnecessary tests, and other inefficiencies that fail to add value to the healthcare system; to aim for *universal coverage* and cover every American; to *provide portability* to allow Americans to keep coverage when jobs are lost and to eliminate coverage denial based on preexisting conditions; to *guarantee choice of plan*; to *invest in prevention and wellness*; to *improve patient safety and quality control* by expanding health information technology; and to *maintain long term sustainability* by reducing cost growth and improving efficiency.

The 2010 budget allocates $76.8 billion to support the mission of the Department of Health and Human Services, including $19 billion to accelerate the adoption of electronic medical records to support the American Economy and Recovery Act signed into law on February 17, 2009, which calls for temporary incentives, starting in 2011, to Medicare physicians who use a certified electronic health record. The idea is that electronic medical records improve the quality of healthcare, prevent unnecessary spending, and reduce medical errors. The act also calls for research funds to determine effective medical treatments, and the 2010 budget provides $1 billion for that effort to help doctors and patients make more informed decisions to reduce wasteful spending on ineffective procedures and treatments. To support the healthcare workforce, the budget has allocated $330 million to support shortages of providers in certain areas, including primary care. Another part of the budget creates a reserve fund of $630 billion over ten years, half funded by projected new revenue and half by projected savings from health proposals that are presumed to be enacted.

In March 2009, insurance industries penned a letter opposing Obama's plan to increase competition in the market by creating a government plan FEHBP available to more Americans. In the letter, signed by America's Health Insurance Plans (AHIP) President and CEO Karen Ignagni and Blue Cross Blue Shield Association, insurance companies wrote that "creating a new government-run plan would thwart the ability of the healthcare sector to implement meaningful delivery system reforms, exacerbate the cost-shift from public programs to consumers and employers in the private market, and destabilize the employer-based system" (Young, 2009). The inclusion of a government plan is strongly favored by Democrats and strongly opposed by Republicans and has the potential to be a kink in trying to pass Obama's plan.

In my opinion, there are some very good goals that the 2010 budget provides suggestions toward solutions. I support the Obama administration's move to electronic medical records. President George W. Bush's first health information czar, David Brailer, estimates that it would cost about $75-100 billion to implement electronic health record systems and that the U.S. would save about $200-300 billion annually by reducing duplicate records, reducing record keeping errors, avoiding fraudulent claims, and increasing coordination between healthcare providers (Mearian, 2009). It is important to research effective treatments and procedures, but the results will be useless until there is a system in place that rewards quality of care over quantity of care and provides physicians will not have incentives to seek efficiency. Like with any politician, it will be interesting to see how Obama can deliver on his campaign promises, which included tax credit for premiums and covering a portion of businesses' medical costs to decrease employee premiums.

Baucus's Plan

As a current United States Senator and Senate Finance Committee Chairman, Max Baucus's vision of a plan is similar in respect to that of Daschle and Obama. Baucus's Health Insurance Exchange would include only private plans that choose to participate to allow the uninsured Americans to "shop around" for the best plan from private insurers at the local, state, regional, and national levels and would eliminate discrimination based on preexisting conditions. Baucus's plan purports is that he would believe in mandatory coverage for all Americans, whereas, Obama favors making health care accessible and affordable for all, not mandatory. Baucus also proposes changing Medicaid eligibility requirements to cover an additional 7.1 million low-income Americans below the poverty line.

To help Americans afford plans, the primary tools for finance will be tax credits and subsidies. Individuals and families participating in the Exchange that are below 400% of the federal poverty level will be eligible for a tax credit. To help these businesses offer employer-sponsored plans to their employees there would be a small business tax credit that would phase out with increased firm size and earnings. Also with interest to businesses, those that do not offer health benefits to employees would be required to contribute to a fund to cover the uninsured; small businesses would be exempt from this requirement.

If the government is going to offer subsidies for insurance as expressed, the government must ensure that subsidies are being used appropriately. The same can be said if Congress decides to mandate coverage; there would need to be a system in place to monitor compliance. Sen. Baucus suggests that the insurance company could certify that an American is covered by

using the U.S. tax system as an intermediary between the taxpayer and the government. In my opinion, it should not be a function of the tax system to be the "middle man." Furthermore, there already exist penalties for not filing taxes, so any additional penalties for not carrying health insurance may not be enough to encourage people to seek coverage. Therefore, if the U.S. does move to requiring health insurance as suggested by the Baucus plan, better enforcement must be found.

One promise of the proposed Health Exchange is that it would have the "authority to implement mechanisms to ensure that plans enrolling sicker-than-expected people would not suffer a financial disadvantage compared to those enrolling healthier people." After bailing out parts of the financial sector in 2008 and 2009, the federal government has established precedence in aiding struggling companies. With the idea that if insurance companies suffer a financial disadvantage than they will be supported by the government, there is no discouragement of insurance companies taking on riskier pools than warranted knowing they can charge higher premiums and apply for federal assistance when struggling. While I do not believe insurance companies would be so brazen, there still must be means to prevent an abuse of the system. We must find solutions other means to encourage insurance company participation without having insurers expect an automatic rescue.

To decrease cost, the Baucus plan would address five points: first, "invest more to detect and eliminate fraud, waste, and abuse in public programs;" second, "address overpayments to private insurers in the Medicare Advantage program;" third, "increase transparency of cost and quality information and would require disclosure of payments and incentives to providers by

drug or device makers that may lead to biased decision-making;" fourth, "consider careful reforms of medical malpractice laws that could lower administrative costs and health spending throughout the system, while ensuring that injured patients are compensated fairly for their losses;" and fifth, "explore targeted reforms of the tax code to make incentives more efficient, distribute benefits more fairly, and promote smarter spending of health care dollars by consumers themselves." I support each of these points.

I also support Baucus's idea to make the Exchange self-sustaining after a few years of federal assistance by assessing participating insurance companies a small fee that could be added to the premiums. The argument that this fee paid by the insured in their premium is covered partially by subsidies is moot because the wealthier and the insured, who are not be eligible for subsidies would bear the majority of costs.

A Brief Look at Other Proposals:

The *Commonwealth Fund's Commission on a High Performance Health System* created their "Path to a High Performance U.S. Health System: A 2010 Vision and the Policies to Pave the Way" that would guarantee affordable coverage for all by 2012, improve health outcomes, and decrease health cost growth by $3 trillion by the year 2020 if started in 2010. A national health exchange, not unlike that of Sen. Baucus's proposal, would create a national exchange of private and public plans from which people can make choices. To make premiums affordable, premium subsidies would be provided and tied to income. One item specific to the Commission's proposal is the idea of "referenced pricing," or finding the lowest costing equally effective drug, procedure, or treatment and making that the reference price. Patients then may

choose a more expensive drug, procedure, or treatment and pay the difference out-of-pocket.

Most conservative proposals focus on the idea of market-based results and the idea that if taxes are cut more people will seek coverage with their savings. The *Health Care Freedom Coalition* (HCFC) is not unlike many liberal proposals in that it calls for free choices, levels tax breaks no matter where the patient is enrolled in a plan (in employment or not), pooling of small groups such as small businesses to benefit like a larger insured pool with lower premiums, and transparency of provider pricing and quality. Differences include creating vouchers for the uninsured for private health care and nonexistence of price controls, mandates for coverage, and minimum plan benefits. Of the differences, I understand conservative arguments against a central government agency like Daschle's Board or Baucus' Exchange, but having a group of healthcare experts helping people make their own decisions sounds more like common sense than does multiple layers of bureaucracy. Furthermore, conservative arguments against the United States developing into a single-payer system with government footing the bill for healthcare are valid, and most liberal proposals are some form of a public-private hybrid and not 100% government run.

Additional Thoughts:

As mentioned in previous discussions of plans, I support the ideas of moving to electronic medical records, protection of physicians from high malpractice insurance and a cap on noneconomic awards to plaintiffs as well as increased fraud investigation and stiffer penalties.

Health insurance is something that is a personal decision but should not be out of reach for the public. In that respect, I believe that access to affordable heath insurance is a right. Currently, I lean toward supporting government subsidies for people to make health insurance available to anyone who wants coverage, but I do not agree with arguments to mandate coverage due to the high costs to the government and the loss of the individual's right to "opt in." Perhaps if we do not mandate health insurance coverage and offer small subsidies, the government could give larger subsidies to people who do "opt in." As compared to a one-level income where an individual either receives a subsidy or does not, I like the idea of a phase-out concept that would discourage people from attempting to get below a one-level income.

I support a refundable tax credit on a sliding income scale because it would appeal to a greater population compared to a tax deduction or exclusion, both of which do not help the poor who generally use the standardized deduction. The tax credit would allow Americans with moderate levels of income to benefit, and the refundable portion provides annual benefits to low-income Americans as well.

Furthermore, mandating that private insurers cover those with costly preexisting conditions will increase the cost of healthcare for everyone because the risk and costs will be spread across the board. Do we promote basic policies with high deductibles that are affordable to healthy people and only offer government assistance to those that need help covering an expensive preexisting condition? Placing healthier people in a pool with those with poorer health will lower the costs for the poor, while also increasing the costs for the healthy. On the other hand, the cost of insurance for the healthy is already inflated because of the cost shifting of

accounting for the uncompensated care for the uninsured, so having more Americans covered by health insurance could result in a decrease in cost shifting, which in turn would decrease the inflated premiums more than premiums would increase as a result of the increased riskiness in the pool.

No matter how Congress chooses to use subsidies, the CBO's 2008 report on issues in analyzing health care reform says that no matter the size of the subsidy, a small portion of Americans will still choose not to take the subsidy. I believe that it will be important to calculate the size of this population to determine if the costs of covering these uninsured and the cost of the subsidies is less favorable compared to other systems.

While there has been some excitement in the past about healthcare reform, this is arguably the first time in 60 years that Americans have so keenly listened to economics and finances. Therefore, now is the perfect time to strengthen the effort to educate the public not only of the health benefits but also the economic benefits of quitting smoking, improving diets, and exercising as well as how we cut costs by not just treating illnesses but working harder to prevent illness.

Looking back at the Clinton plan in 1993 and how the delay before it was sent to Congress gave opposition groups time to mobilize against it, if Obama is going to be successful in passing his plan, he would wise to have Congress draft a plan quickly. However, Republican groups are already arguing Democrats trying to push a healthcare plan through quickly by launching a television ad campaign in late March 2009 which argues that a hastily passed healthcare plan is potentially not thorough enough, as was the case with Congress pushing

bailouts and not accounting for executive bonuses in the legislation. With government spending increasing in 2009 to support the financial sector, it will be difficult for Congress to make the needed changes to the health care system without either increasing the deficit or increasing taxes in the short term. While neither is immediately desirable, the benefits of government spending to fix health care now would outweigh its costs in the long run.

Finally, legislation will be difficult with expected interest group opposition. There are certain agency costs that will need to be addressed because as businesses, no part of the health care system, such as a hospital or insurer, is particularly willing to give up a slice of the health care pie without proper incentives.

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Conclusion

Having explored how insurance programs developed as band-aids to fix other problems, such as Medicare's birth to give the elderly targeted with high premiums a chance to obtain affordable healthcare, I caution that whichever solution develops must work to change the system rather than just bandage it. Medicare was not only a quick fix but provided the American system with government insurance programs allowing millions of Americans access. Today's problem is that about75 million people are either uninsured or underinsured. The uninsured raise the cost of premiums for the insured, causing an increasing number to drop their coverage, become uninsured, and then the process repeats itself in a vicious cycle. The fact that medical bills are the number one cause of bankruptcy is disconcerting, but not surprising, since when an unexpected illness or injury strikes, with costly medical bills too large for the uninsured, they must enter bankruptcy for protection. To protect American families and businesses, legislative action is need to to help lower premiums. I propose that federal legislation that would include changing medical malpractice laws, cutting down on fraud, and forcing electronic medical records. Furthermore, some public-private hybrid with an autonomous central agency that can develop plans and increase competition in the marketplace is, in my opinion, the best direction. The creation of subsidies and tax credits as well as movement toward a pay for quality system are good ideas to make coverage affordable. Finally, I believe we must not solely employ reactionary medicine but take strides to protect our health before we fall ill. To that end, there must be action to decrease the gap between primary care and specialization to encourage more physicians to enter primary care.