

Health Insurance in the United States

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About two-thirds of Americans under the age of 65 have health insurance coverage. This leaves 43 million without. Sixteen million people with insurance are underinsured. Lack of insurance and inadequate insurance have serious consequences for individuals, families, and the country.

This article provides facts about the current system of health insurance in the United States and government reform efforts.

Keywords: Health insurance, medical bankruptcy, underinsured, uninsured, universal healthcare.

Eric was living the American dream. He earned a bachelor's degree in nursing and then a master's degree in nurse anesthesia. He enjoyed his job and taught at a nurse anesthesia school. He was married to the love of his life and they had 2 beautiful, healthy children. Life was good. On January 20, 2008, he went snowmobiling with a friend. He hit a tree and died. His wife, Ellen, was suddenly a widow—his 2 small children fatherless.

Ellen was a stay-at-home mom. Eric's job provided health insurance for the family. Upon his death, Eric's health insurance was cancelled within 24 hours without notification. Ellen was now faced with the task of insuring herself and her children while dealing with the grief. Eric's employer paid the cost of COBRA (Consolidated Omnibus Budget Reconciliation Act) until Ellen could find an alternative. She enrolled the children in SCHIP; the State Children's Health Insurance Plan. She was embarrassed to be accepting "charity," but getting a nongroup policy for her and the kids, ages 2 and 4, was financially impossible. Ellen had to fight to obtain SCHIP because regulations mandated that COBRA lapse before SCHIP could be initiated. Ellen was adamant that the kids would not go one day without health insurance. She won that battle, but it was difficult. She was denied an adult individual policy through the same company that cancelled Eric's policy. The reason the insurance company gave was that she filled a prescription for an antidepressant in the time period following her husband's death. This "preexisting condition" made her ineligible.

This story is heartbreaking and yet all too familiar. About two-thirds of Americans under the age of 65 have health insurance coverage. This leaves 43 million without.¹ Half of these 43 million are white and 80% live in a family in which someone works.¹ Why are they uninsured? Employers are not required to offer health insurance and one-fourth of workers are not offered coverage.¹ Half of these remain uninsured because they cannot afford nongroup coverage and do not qualify for public programs.¹ People with health problems, particularly those with chronic conditions, pay premiums for nongroup in-

urance that are up to 40% higher than their healthier counterparts.¹ It is not surprising that just 7% of Americans under the age of 65 purchase nongroup health insurance policies for themselves or their families.¹

Having insurance isn't always the solution. Twelve percent of insured adults, nearly 16 million, are underinsured.² These are people who are insured all year but report medical expenses greater than or equal to 10% of income or health plan deductibles greater than or equal to 5% of income.² This means an estimated 61 million, or 1 out of 3 adults, have either no insurance, sporadic coverage, or insurance that exposes them to catastrophic medical costs.² *Consumer Reports* found 29% of people who have health insurance are underinsured with coverage so meager they postpone medical care because of costs.³ The national survey went on to find 43% of those surveyed with insurance said they were "somewhat" to "completely" unprepared to cope with a costly medical emergency over the coming year.³ Sixteen percent had no health plan at all, including many working respondents whose jobs did not offer insurance or who could not afford the premiums or deductibles of the available plan.³

The median household income of those who were underinsured was \$58,950 and 22% lived in households making more than \$100,000 per year.³ This result is not surprising considering that premiums for employer-sponsored health insurance have been rising 4 times faster on average than workers' earnings since 2000.⁴ The average employee contribution has increased more than 143% with out-of-pocket costs for deductibles, copayments for medications, and coinsurance for physician and hospital visits rising 115%.⁴

A Disturbing Picture

This data give a disturbing picture of health insurance for American adults under the age of 65. We are the only developed nation on Earth that does not guarantee healthcare to its people.⁵ We are nearly alone among developed nations in our failure to commit healthcare as a human right.⁵ Why is that? Individualism and self-determination, distrust of government, and reliance on the private

sector to address social concerns are typical American ideologies.⁶ The roots of our employer-based health insurance system go back to the 1900s when businesses and unions provided sickness funds. By 1915, one-third of the nonagricultural labor force received sickness funds.⁷ In 1912, Theodore Roosevelt ran on the Progressive Party Platform, promising “protection of home life against the hazards of sickness, irregular employment and old age through the adoption of a system of social insurance adapted to American use.”⁷ This was the first of many attempts at government-based universal health insurance to fail. The factors involved in Roosevelt’s failure and the many that followed are numerous. Consistent themes among them are beliefs and values unique to America. One of the primary arguments of opponents to the Progressive Platform was that forcing workers into insurance was an affront to traditional American values of individualism.⁷ The same argument is still present 100 years later.

The 1930s saw the rise of private health insurance replacing traditional sickness funds. Blue Cross and later Blue Shield came into existence. This was aided by the development of actuarial science, allowing insurers to transform premiums into promises of benefits based on scientific data; this helped health insurance companies become profitable.⁷ Government intervention further strengthened the business of employer-based health insurance. In 1942, Congress limited wage increases but permitted the adoption of employee insurance plans.⁸ In 1945, the National War Labor Board ruled that employers could not modify or cancel group insurance plans during the contract period.⁸ And, in 1949, the National Labor Relations Board ruled wages included pension and insurance benefits, opening the door for unions to negotiate benefit packages on behalf of its members.⁸ The most influential aspect of government intervention is the 1954 Internal Revenue Code exemption of employer contributions to employee health plans from employee taxable income.⁸ Employer payments for health insurance are not taxed as income to the employee and contribution to employee health plans are deductible for employers.⁹ These incentives support employer-based health insurance.

Some Help From the Government

The government does step in to provide a safety net for the gaps in private insurance. These government programs include Medicare, Medicaid, SCHIP, the Military Health Services System (MHSS), Department of Veterans Affairs (VA), Indian Health Service, workers’ compensation, and a variety of state and local government programs. Ellen was able to use 2 of these programs. COBRA is a law Congress passed in 1986 giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates.¹⁰ Under COBRA, the participant must pay 102% of the full

premium for previous employment-based coverage.¹ Ellen was fortunate that Eric’s employer picked up the cost of coverage. SCHIP is Title XXI of the Social Security Act and is jointly financed by the federal and state governments and administered by the states.¹¹ Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures.¹¹ Two-thirds of states require that children be uninsured for a period of time before enrolling in SCHIP.¹ This is what Ellen faced when switching from COBRA to SCHIP. Breaks in coverage occur because of the public programs’ requirements for eligibility, enrollment, and reenrollment. More than half of the single women in Medicaid at the beginning of the year lose their coverage before the end of the year.¹ The “safety net” that these government agencies provide are a maze of forms, rules, and regulations that vary from state to state and agency to agency.

Uninsured and Underinsured: What do they mean?

So what does being uninsured and underinsured mean in terms of health? Health insurance is the key to obtaining needed healthcare services. The uninsured and underinsured simply cannot get the care they require. The World Health Organization ranked the US healthcare system 37th in the world and last among all countries in the industrialized world.¹² Rankings were based on overall level of population health, health inequalities within the population, overall level of health system responsiveness, distribution of responsiveness with the population, and the distribution of the health system’s financial burden within the population.¹² Evidence from the scientific literature overwhelmingly shows that those without insurance in the United States suffer worse health and die sooner than those who have coverage.¹ The Institute of Medicine reports:¹

1. Uninsured people receive too little medical care and receive it too late; as a result, they are sicker and die sooner.
2. Uninsured adults have a 25% greater mortality risk than adults with coverage. About 18,000 deaths among people younger than 65 are due to lack of coverage every year.
3. Uninsured women with breast cancer have a risk of dying that is between 30% and 50% higher than for insured women.
4. Uninsured car crash victims receive less care in the hospital and had a 37% higher mortality rate than privately insured patients.
5. Uninsured individuals with diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness have consistently less access to preventive care and have worse clinical outcomes than do insured patients.
6. If common childhood conditions, such as asthma, anemia, and middle ear infections, are left untreated or

improperly controlled—which can happen if a family lacks insurance—they can affect mental and language development, school performance, and hearing.¹

The poorer health and shorter lifespan of uninsured people is “health capital” lost (Figure). These losses are estimated at \$65 billion to \$130 billion in health capital each year,¹ which is one of the hidden costs of sustaining a large uninsured population.

On a personal level, being uninsured or underinsured can be devastating. Medical problems contribute to about half of all personal bankruptcies.¹ People filing for bankruptcy because of medical bills are usually middle class homeowners.¹³ The average medical debtor filing for bankruptcy is a 41-one-year-old woman with children and at least some college education.¹³ Most own homes.¹³ They differed from others filing for bankruptcy in one important respect: they were more likely to have experienced a lapse in health insurance coverage.¹³ Those with continuous coverage had ruinous medical bills.¹³ Three-fourths were insured at the onset of the bankrupting illness.¹³ Few medical debtors (3%) had elected to go without coverage.¹³ Of the uninsured who declared bankruptcy, 56% said that premiums were unaffordable, 7% were unable to obtain coverage because of preexisting medical conditions, and most others cited employment

issues, such as job loss or ineligibility for employer-sponsored coverage.¹³ Debtors’ out-of-pocket medical costs were often below levels that are commonly labeled catastrophic.¹³ In the year before bankruptcy, out-of-pocket costs (excluding insurance premiums) averaged \$3,686.¹³ Presumably, such costs were often ruinous because of concomitant income loss or because the need for costly care persisted over several years.¹³ At a time when health should be the focus, financial survival is.

On a national level, our healthcare system is economically draining. Total health spending is 15.3% of our gross domestic product.¹⁴ This is the highest share of any country, and more than 6 percentage points higher than the average of 8.9%.¹⁴ We rank 37th while spending more. Public dollars pay most of the \$35 billion in uncompensated care of the uninsured, and this cost is paid by taxpayers.¹ Government revenues are 46% of total health spending in the United States, well below the average of 73% in other countries.¹⁴ Private insurance accounts for 36% of total health spending in the United States, the largest share among countries.¹⁴ This affects several segments of our economy:

1. Surging healthcare costs slow the rate of job growth by making it more expensive for companies to add new workers. They also suppress wage increases for current

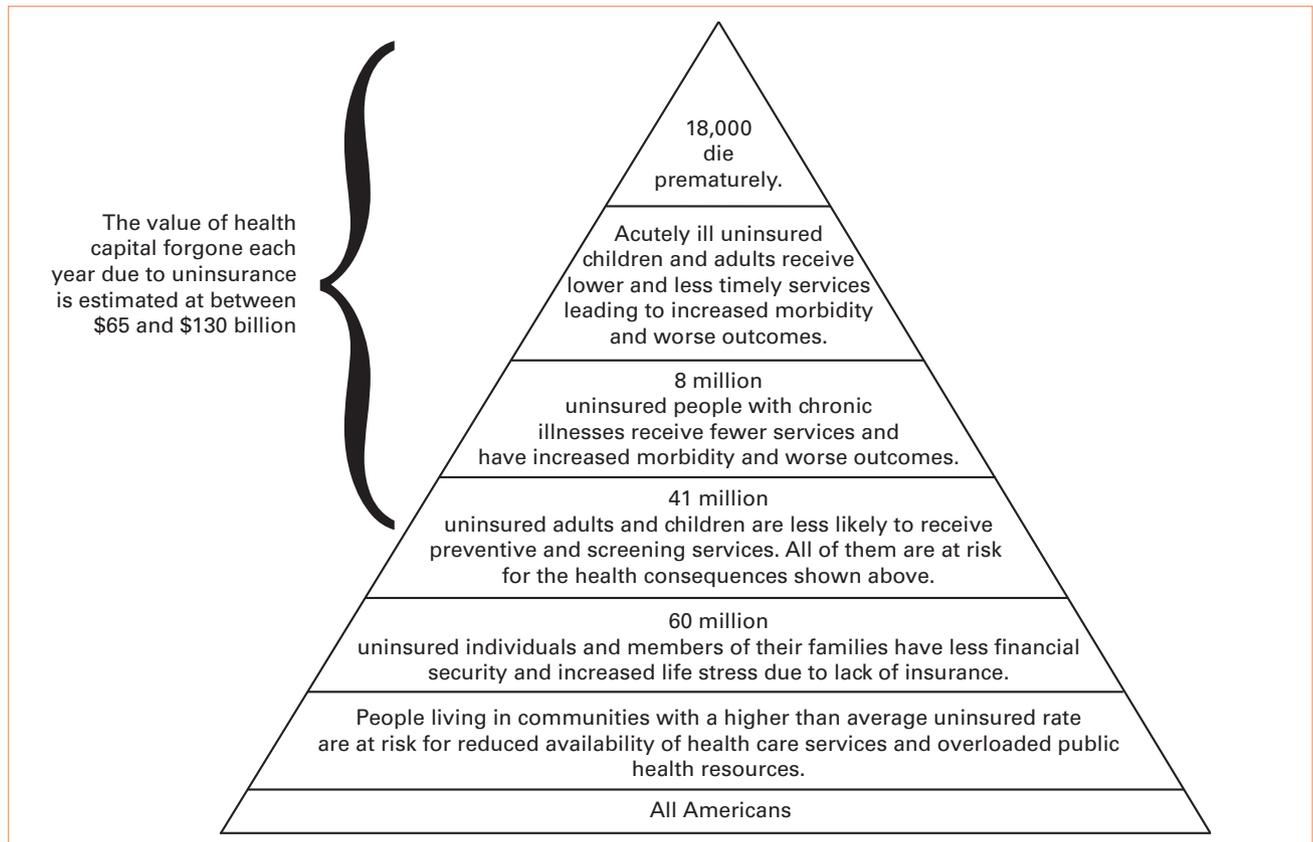


Figure. Hidden Costs, Value Lost

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workers by driving up total compensation costs.¹⁵

2. As healthcare costs rise, corporate operating margins are cut, which reduces the capacity of firms to grow by investing in research, plant and equipment.¹⁵

3. High and escalating out-of-pocket costs are forcing families to delay mortgage payments or sell their homes, cut back on normal household expenses such as food and utilities, and take on onerous medical debt.¹⁵

4. High medical costs can require retired families to spend hundreds of thousands of dollars out of their savings for out-of-pocket healthcare expenses.¹⁵

5. High insurance costs are eroding the ability of firms to fund current levels of pension and health benefits.¹⁵

6. This puts American firms at a steep disadvantage in world markets, where they have to compete against companies with much lower healthcare costs in the nations where they operate.¹⁵

7. Rapidly escalating costs are producing severe long-term budgetary problems in the public sector affecting the solvency of federal and state health insurance programs, such as Medicare and Medicaid.¹⁵

Highmark Insurance

Ellen's experience was with Highmark in Pennsylvania. Highmark Inc ranks among the nation's leading health insurers and is the largest health insurance company in Pennsylvania based on membership.¹⁶ It administers state and federal insurances programs such as SCHIP and Medicare.¹⁶ Highmark increased premiums from 31% to 55% in 2004, the seventh consecutive jump,¹⁷ and reported a profit of \$342 million with reserves of \$2.8 billion in 2005.¹⁸ A proposed merger with Independence Blue Cross would have garnered a \$1 million dollar raise for Highmark President and Chief Executive Officer Ken Melani, MD, bringing his total salary with incentives to \$3.9 million. Other executive compensation proposed for the new company included vice president of government services, \$1.55 million, chief executive officer of Highmark Life and Casualty, \$1.08 million; and executive vice president of finance and chief financial officer, \$1.7 million.¹⁹ This while Ellen felt embarrassed putting her children into a "charity" health insurance plan. Then she was humiliated by being turned down for an individual plan because she took a physician-prescribed medication to help her be there for her children during Eric's funeral.

In 2005, 450,000 fewer Pennsylvania residents had job-based insurance than in 2000. During this same time period, uninsurance rates in Pennsylvania rose from 7.6% to 9.7%.²⁰ In June 2008, dozens of protestors rallied in front of Highmark's headquarters. Among them were physicians and social workers.²¹ It was one of 19 nationwide protests with the largest coinciding with the annual convention of the health insurance industries trade group, America's Health Insurance Plan (AHIP).²¹

Highmark is a business. Successful businesses make

money. Highmark is successful. The Pennsylvania Insurance Commissioner ruled that Highmark's multibillion dollar reserves and surpluses were appropriate to protect the companies' policyholders.²² The proposed Highmark/Independence Blue Cross "megamerger" would have paid millions to its executives. It would have formed the third largest health insurance company in the country and the largest in Pennsylvania. The new company would have controlled 53% of the Pennsylvania health delivery market and would have had an estimated 8 million enrollees, the majority of which would be Pennsylvanians.²³ While this merger did not occur, monopolization of regional health insurance markets is common. The American Medical Association studied competition in health insurance in 313 metropolitan areas in 44 states.²⁴ It found that the majority of areas have a single health insurer controlling the market, while competition is undermined in hundreds of others.²⁴ In the past 12 years, the US Department of Justice has challenged only 2 of more than 400 mergers.²⁴ Without competition, health insurance companies can dominate their customers. Highmark is one example of many.

The average compensation of the highest paid executives in 11 companies studied by Families USA was approximately \$15.1 million in 2002.²⁵ The highest paid of these executives was Norman Payson, former chairman and chief executive officer of Oxford Health Plans with compensation of \$76 million.²⁵ The 11 companies studied paid their most highly compensated executives a total of over \$166 million in 2002.²⁵ In 2006, the nation's 6 biggest private health insurers collectively earned almost \$11 billion in profits.²⁶ How many of their present or former costumers face bankruptcy? How many cannot make their mortgage payment, save for college, or invest for retirement? How many businesses struggle to provide health insurance to their employees?

It would be easy to paint health insurance companies as the problem. They are not. They employ millions of people, provide a necessary service, pay taxes, and operate within legal guidelines. Nineteen thousand people are employed by Highmark.¹⁶ In 2007, they contribute \$100 million toward programs and initiatives to strengthen their communities and to increase access to healthcare services.¹⁶ They pay \$190.8 million in federal, state, and local taxes.¹⁶ Highmark Medicare Services earned certification by the Customer Operations Performance Center for meeting stringent standards in customer service and is the first Medicare contractor in the country to receive the certification.¹⁶ Highmark Inc. was designated a Certified Age-Friendly Employer, receiving scores higher than any other company awarded this designation and is the first plan in the Blue Cross Blue Shield network to earn the distinction.¹⁶ Highmark is a good company as are other insurance companies. The first law of improvement: Every system is perfectly de-

signed to achieve the results it gets.⁵ Our healthcare system is designed to achieve these results.

Ellen and her children are lucky. Ellen found an individual policy with another company. Although the deductibles and copays are high, she is grateful to have it. They have insurance and are healthy enough not to need it. Not everybody who is uninsured or underinsured ends up suffering serious medical or financial consequences. At any one time, only a small percentage of people will have severe health problems. But the whole point of insurance is to protect against a misfortune that, however unlikely, would be catastrophic if it struck.²⁷ The current system leaves millions unprotected. These are the numbers: 43 million uninsured, 16 million underinsured, 37th in the world for health care, \$130 billion in lost health capital, \$35 billion in uncompensated care. And, it is not getting any better. The unemployment rate rose to 10.2% in October 2009, the highest rate since April 1983, with 15.7 million people unemployed.²⁸

Obama Administration and Congress

The Obama administration has made healthcare reform a priority. Heated debates and strong opinions about proposed reform go on as Americans continue to struggle to meet their healthcare needs. Remote Area Medical Volunteer Corps, Pioneers of No-Cost Health Care, held an 8-day free clinic at The Forum in Inglewood, California, on August 14, 2009.²⁹ Almost 9,000 people came to be treated by volunteer doctors, dentists, nurses, and technicians.²⁹ They came several days in a row waiting long hours to be seen; the first day to get a number, the second day to wait in line, and the third day inside to be seen.²⁹ Total value of volunteered care reached 3 million dollars.²⁹ President Obama has said, "So let there be no doubt: healthcare reform cannot wait, it must not wait, and it will not wait another year."³⁰

Congress drafted legislation to overhaul the current system. Three separate committees in the House of Representatives; Energy and Commerce, Ways and Means, and Education and Labor, came together to write H.R. 3200. The bill, America's Affordable Health Choices Act of 2009, was passed 31 to 28 in committee at the end of July. In an open session on November 7, the House of Representatives voted 220 to 215 in favor of the bill. The bill now moves to the Senate where it is likely to be considered in early 2010. The Senate Health, Education, Labor and Pension (HELP) Committee, led by the late Senator Kennedy, passed its version of healthcare reform. The Senate Finance Committee bill is complete and is currently being debated in committee. The final version must be passed in committee. The Senate then must reconcile its 2 bills and vote. The House passed H.R. 3200 and the Senate must pass its versions. Then the two bills will be merged into one by a conference committee. This committee is a panel of House and Senate conferees

formed to reconcile differences in legislation that has passed both chambers.³¹ This finalized bill goes to the President for approval.

Healthcare reform is closer than ever before, but not guaranteed. It is possible, as in 1993 under President Clinton, legislation will be voted down, and, if so, the current system would remain. The House and Senate bills create new rules for private insurance and provide all Americans with health insurance. The new rules for private health insurance are:³²

1. Insurance companies will be prohibited from refusing coverage because of medical history. No exorbitant out-of-pocket expenses, deductibles, or copays. Insurance companies will have yearly caps on how much they can charge for out-of-pocket expenses.

2. Insurance companies must fully cover, without charge, regular checkups and tests that help prevent illness.

3. Insurance companies will be prohibited from dropping or watering down insurance coverage for those who become seriously ill.

4. Insurance companies will be prohibited from charging more because of gender.

5. Insurance companies will be prevented from placing annual or lifetime caps on coverage.

6. Children would continue to be eligible for family coverage through the age of 26.

7. Insurance companies will be required to renew any policy as long as the policyholder pays the premium in full. They will not be allowed to refuse renewal because someone became sick.³²

If this legislative reform is passed, it will dramatically change the private health insurance market.

Providing health insurance to Americans currently uninsured is addressed in the House and the Senate HELP bill with a government public option. The Senate Finance Committee bill has healthcare cooperatives as the solution to the uninsured. There has been a lot of publicity and misinformation about the public option from both sides of the debate. This started before any legislation made it through committee. There is ideology and money sparking emotional responses to this issue. Healthcare firms and their lobbyists have spent \$1.4 million daily from January to March.³² From April to June, Blue Cross and Blue Shield Association spent 2.8 million dollars, an increase of more than a million dollars.³³ Metlife Group spent \$1.7 million, a 50% increase. Allstate spent \$1.5 million and America's Health Insurance Plans approached \$2 million.³³ The American Medical Association has spent a total of \$8.2 million as of June this year.³³ Lobby money is used to influence the direction of legislation and sway public opinion.

As providers and consumers of healthcare we should keep our eye on the ultimate goal—providing affordable insurance coverage for all. In his dying days Senator Ted Kennedy wrote, "What we face, is above all a moral issue;

at stake are not just the details of policy, but fundamental principles of social justice and the character of our country.”³⁴ Democrats, Republicans, Independents, liberals, conservatives, and centrists should all be able to agree that we want a country where a widow can grieve her loss, instead of fighting for insurance for herself and her children. Where American citizens do not have to spend 3 days in line to receive charity care from volunteer clinicians. Where the quality of medical care is not dependent on your job title or your income bracket. Where illness does not bankrupt.

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