THE UNDERWRITING OF AMERICAN HEALTHCARE:

ONE HUNDRED YEARS OF REFORM AND THE NEED FOR A NEW PARADIGM

by

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ABSTRACT

In 2009, healthcare costs in the United States totaled $2.5 trillion dollars and constituted more than 17% of GDP.[1, 2] Healthcare inflation has trended higher than general CPI for more than twenty years and this pattern is expected to escalate. The U.S. currently has the most expensive healthcare system in the world both in terms of absolute dollars and per capita spending. The underwriting for these costs however, is highly fragmented and currently leaves 47 million Americans to either cover the full costs themselves or forego treatment.[3] Recent enactment of healthcare reform via the Patient Protection and Affordability Act and the Health Care and Education Reconciliation Act promises to expand insurance coverage as well as redress systemic shortcomings in the delivery and financing of healthcare. However, there is considerable debate as to what will really be accomplished by this latest reform attempt as well as considerable opposition its promulgation. The current debate over healthcare reform is a continuation of a conflict that arose more than one hundred years ago when powerful business, political and medical interest groups allied themselves against changes to the status quo. In 2010, it is simply "déjà vu all over again".*

This paper will present the salient features of the current healthcare model in the U.S. It details the elements making up the three segments of the model and the factors that led to their entrenchment. The paper will also trace the evolutionary reformation of healthcare and the forces that have shaped the model we have today. It will highlight the process surrounding the passage of the latest reform measure as well as specific requirements and protections being introduced by it.

* Quote attributed to Yogi Berra

As other countries have faced the same issues with respect to the role of government in ensuring the health and welfare of its citizens, a comparative review of the healthcare financing and delivery models in Great Britain, Germany, France and Canada will be presented. The paper will further examine the governance structures in these countries versus those in the U.S. to gain insight as to why the U.S. has lagged behind its democratic peers in implementing healthcare reform.

Lastly, this paper will seek to reframe the current U.S. debate over healthcare reform from one centered on underwriting principles to one centered on national values.

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CHAPTER 1

CURRENT U.S. HEALTHCARE DELIVERY AND FINANCING MODEL

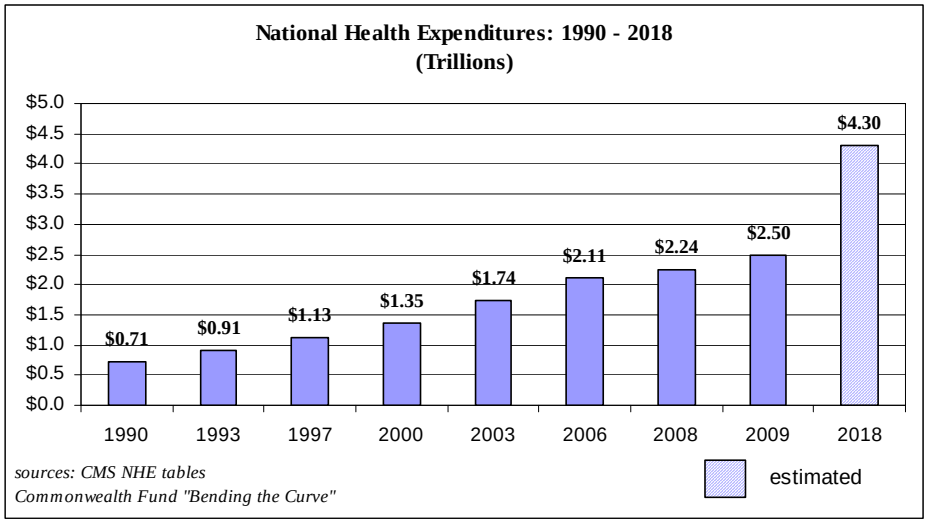
Overview

The U.S. healthcare system can provide you with a host of medical and technological wonders. Failing or damaged body parts can be repaired or replaced so as to restore functioning and health. In fact, many body parts have become fungible. They can be sourced from a commercial manufacturer or harvested from living or deceased donors. Replacements are available in whole (e.g. titanium joints, organs, etc.) or in part (e.g. heart valves, eye lenses, etc.). In addition, the U.S. health care system can provide you with medical bridges (e.g. dialysis for failing kidneys) until a more permanent fix becomes available, such as an organ transplant. Furthermore, a host of devices are available that can be implanted into the body to reverse damage (e.g. stents to open clogged arteries), improve functionality (e.g. defibrillators to regulate erratic hearts), reduce pain (e.g. neurostimulators) or compensate for functional absence (e.g. cochlear implants). The system has also fostered impressive advancement in the assessment of illness, defect and injury. Sophisticated laboratory testing and imaging equipment have allowed for earlier and more precise diagnoses. In addition, the system has actively facilitated pharmaceutical and biotech innovation which has led to a phalanx of vaccines and therapeutic agents that correct, ameliorate, adjust or cure a wide variety of conditions and diseases. Lastly, the U.S. healthcare system has attracted and fostered a highly skilled and trained clinical workforce. Access to these many wonders however, has often been limited to those Americans

who are fortunate enough to have had either adequate health insurance or compensatory personal wealth.

Escalation in healthcare costs has consistently trended higher than general inflation as measured by the consumer price index. A variety of factors including increase in the cost of new technologies, clinician wage growth, higher levels of utilization, higher intensity of services, waste/inefficiency, abuse and the effects of imperfect market forces have combined to drive U.S. healthcare costs steadily upwards. As seen in Figure 1, the rate of total spending in the past nine years grew from $.71 trillion to $2.5 trillion, for a total increase of $1.79 trillion or 84%. Over the next nine years total spending is projected to grow from $2.5 trillion to $4.3 trillion for a total increase of $1.8 trillion or 72%.

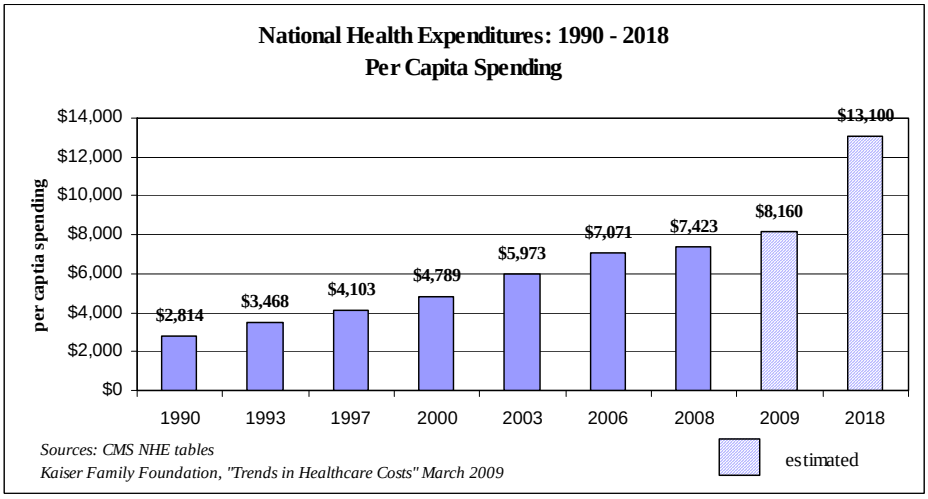
Figure 1. U.S. Health Expenditures 1990 – 2018
(Total Dollars)



Viewed in terms of per capita expenditures, the net change over the past nine years in health expenditures has amounted to $3371, an increase of 70%. The projected change in net spending over the next nine years is expected to be $4940, an additional increase of

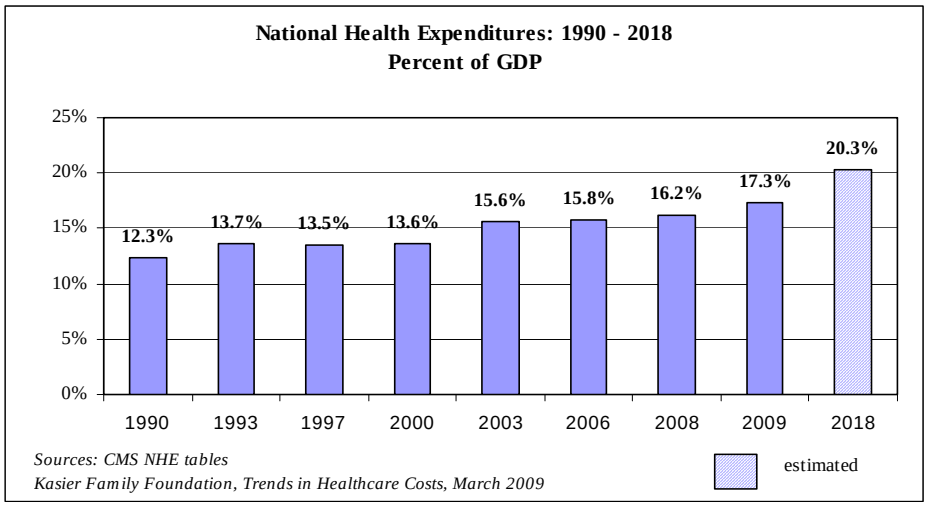
60%. Viewed over the last twenty years (1990 through 2009), per capita spending has increased almost 190%. These expenditures are illustrated in Figure 2.

Figure 2. Per Capita U.S. Health Expenditures 1990 – 2018



Lastly, these costs have had an impact on the overall economy as healthcare expenditures have consumed an ever increasing share of GDP. As illustrated in Figure 3, the percent of GDP consumed by healthcare costs has risen by 40% for the period 1990 – 2009.[4]

Figure 3. National Expenditures as a Percent of GDP 1990 -2018



The opportunity costs arising from the increased consumption of national wealth by healthcare expenditures has implication across a broad front of critical concerns such as national security (i.e. funding for the military), human capital (funding for education) and global competitiveness (infrastructure funding). Thus, the issue has again moved to the forefront of economic policy and reform debate. There is increasing pressure to control healthcare costs given that the U.S. has become the most expensive healthcare system in the world. A comparison of 2006 per capita expenditures amongst several developed nations reveals that U.S. costs exceeded that of the second highest spending country (i.e. Switzerland) by more than fifty percent (see Table 1).[5] This statistic is particularly remarkable given that Switzerland provides universal health coverage to all its citizens, whereas approximately 15.6% of U.S. citizens are without any kind of insurance.[6]

Table 1. 2006 Per Capita Health Expenditures Amongst Select Developed Nations[7]

United States	$6567
Switzerland	$4311
Canada	$3505
France	$3353
Germany	$3247
Australia	$2960
Japan	$2529

The gap in spending between the U.S. and other developed nations is not a new phenomenon. A comparison of 2000 GDP data between the U.S. and the three leading European economies shows that health care spending comprised 9.5% of GDP for France, 5.16 % for Great Britain, 10.6% for Germany and 13% for the U.S.[8, 9]

Spending the most money of any nation on healthcare however has not resulted in superior health outcomes for the U.S. population. According to the 2000 World Health Organization's Annual World Health Report, [10] the U.S. ranked well below many developed nations in several key measures: 32nd for infant mortality, 24th for life expectancy and 54th for fairness (derived from a comparison of the individual financial contribution required and the quality of healthcare received).

When assessed against thirteen of its industrialized peers (Japan, Canada, France, Australia, Spain, Finland, Netherlands, United Kingdom, Denmark, Belgium and Germany), the U.S. ranked 12th (second from last) for sixteen health indicators.[11]

Nevertheless, Americans have tended to view their healthcare system as offering superior technology, services, outcomes and accessibility than the models in other countries. However, American satisfaction with the system appears to be changing. In a recent Gallup survey which asked if the respondents had confidence in their country's "health care or medical systems" 73% of Canadians and Britons said "yes" while only 56% of Americans felt that same way.[12] These data suggest that the current U.S. healthcare delivery and financing model is taking a toll not only on the health of Americans but on their psyche as well. This "dis-ease" arises from the structure of the U.S. healthcare model and its evolution into a multi-tiered, complex, wasteful and fragmented system. The structure and functionality of this model will be further explored in the next section.

U.S. Healthcare Model

The U.S. healthcare system has two main components: a financing structure and a delivery structure. Financing is provided by government and private sources as is the actual delivery of services. It is the alignment of these components into three segments that create the country's current mixed model as shown in Table 2.[13]

Table 2. Alignment of Financing and Delivery Components of the U.S. Model into Three Segments

Segment One - Government Financed/Government Delivery Channels

a) Under this structure, the government predominately underwrites the cost of care out of allocations from the national budget
b) It also predominately provides the delivery channels through healthcare facilities it owns and operates as well as through the clinical and administrative personnel it employs, enlists or contracts with.
c) Examples of this segment include the Veterans Hospital System, Military Treatment Facilities, Bureau of Federal Prisons, Bureau of Indian Affairs Health Services and state/municipal hospitals and clinics.

Segment Two – Government Financed/Private Delivery Channels

a) Under this structure, the government predominately underwrites the cost of care out of state and federal funds (e.g. Medicaid, Medicare and TRICARE) and/or out of funds contributed by the patient in the

form of premiums, payroll deductions and out-of-pocket payments concomitant to receiving health services (e.g. Medicare).

b) Delivery is provided via direct contracts with provider channels or via the use of middlemen (e.g. insurance companies) who in turn contract directly with the providers (e.g. Medicare Advantage plans).

Segment Three – Private Financing/Private Delivery Channels

a) Under this structure, private entities such as charities, non-profit organizations, commercial insurance companies, employers and individuals either fully or partially underwrite the cost of health care through endowments, consumer contributions, premiums or operating funds. This sector however, is dominated by self-insured groups and commercial insurance companies.

b) Services are provided through contracts with private facilities and other providers, although some entities such as trade associations/unions may own health care facilities and employ clinicians to render services.

The current healthcare model is the result of decades of policy initiatives, incremental reform, structural resistance, political agendas, cultural shifts and special interests. The segmentation within the model is not inherently a design flaw. For example, it may be inherently necessary to retain a government financing/service delivery segment for active duty soldiers and their families so as to ensure military

preparedness. It is rather that we have failed to develop a unified social vision strong enough to overcome the structural dynamics and political polarization in our governance processes. This in turn, has produced a healthcare model whose latter two segments contribute to economic dysfunction, social injustice and healthcare disparity. The issues involved in these latter two segments and the need for a paradigm shift are more fully explored below.

Government Financed/Private Delivery Segment

The Medicare and Medicaid programs constitute most of this segment. Both programs were established in 1965 as part of President Johnson's Great Society initiatives. These programs were envisioned as a means to ensure access to health care via government underwritten insurance. These programs were designed for the elderly (who lost their employer-based health coverage when they retired), the disabled (who were either unable to obtain private insurance or who lost their coverage upon becoming disabled) and children (who were disabled or lived in low-income families). Medicare is financed from three sources: deduction from workers' wages during their employment, premiums paid upon activation of coverage and government subsidies drawn directly from the federal treasury. Medicaid, on the other hand, is financed out of joint contributions by states and the federal government with little or no out-of-pocket expenses for the enrollees.

Medicare was an immediate success amongst enrollees as well as providers who could look to a reliable means of payment for services rendered to elderly patients. However, reimbursement was based on a fee-for-service approach which encouraged providers to render unnecessary services to enhance remuneration. By the

mid 1980's criticism over rising Medicare costs fueled a push to privatize the program. This initiative is consistent with the American capitalistic view that government is wasteful and that private industry is more efficient and effective. Both for-profit and not-for-profit health insurance companies were therefore invited to bid to be awarded a Medicare contract. These private Medicare insurance companies would serve as middlemen and "manage" the delivery of services. They would receive a discounted lump sum payment that was based on 95% of fee-for-service rates for every beneficiary enrolled with them. In turn, they would pay the cost of services performed by contracted providers in the managed care company's network. It was assumed that competition in the marketplace would control costs and provide a better array of services. In fact, the opposite occurred. The managed care companies manipulated marketing and enrollment processes so as to target the healthiest segment of the Medicare population (22% of Medicare enrollees require little medical care during the year).[14] By the late 1990's, the practice of "cherry picking" by the managed care companies left all the adverse risk (i.e. the sickest members) to default to that portion of the Medicare program still directly administered by the federal government. While this maneuvering netted managed care companies significant profits, it drove up overall Medicare costs by over $2 billion.[15] This differential was ultimately subsidized by both taxpayers and Medicare enrollees.

The federal government has initiated a number of measures over the years to rein in the costs of the Medicare program. It has reformulated reimbursement for services it administers on behalf of beneficiaries enrolled in traditional fee-for-service Medicare. It is increasing moving towards flat payments for bundled services as well

as pegging reimbursement to quality as measured by benchmarked outcomes. Yet despite such measures, Medicare costs continue to climb. In 2000, Medicare expenditures consumed 2.3% of GDP; in 2005 it equated to 2.7% of GDP and in 2010 it is expected to consume 3.5% of GDP.[16] Approximately one-third of the increase since 2005 however, can be attributed to the enrichment of the Medicare program through the addition of pharmacy benefits (i.e. Medicare Part D).[17] Nevertheless, upward pressure on Medicare expenditures is expected to intensify as "baby boomers" enter retirement age. Enrollment is therefore expected to climb from 45 million in 2009 to 71.3 million by 2025.[18, 19] At that point, Medicare spending will consume 7% of GDP, a figure widely believed to be unaffordable.[20]

Fiscal prudence demands that such public programs operate as efficiently as possible. However, because the U.S lacks a unified vision for the financing of healthcare services, various reform efforts to the Medicare program have instead been shaped by political shifts and special interest pressures. As a result, the financing of the system has undergone variable changes that fail to achieve intended benefits such as greater cost effectiveness. For example, a shift in political ideology that believed the private sector to be the most efficient means of delivering healthcare goods and services resulted in the outsourcing of Medicare services to insurance companies. This change however, did not precipitate the expected cost savings. In fact, in 2007, the federal government paid managed care insurance companies 12% more (i.e. $11 billion) than what would have been spent if the enrollees remained in the federally administered Medicare program.[21, 22] The underlying cause for this misspent largess is the private sector's overhead (including profit margins) which consumes 15% of

every Medicare dollar versus the 1%-3% incurred by the Centers for Medicare and Medicaid Services to administer the same program.[23]

Another shortcoming of this segment of the U.S. healthcare model is the failure by the Medicare program to optimize its marketshare to better leverage cost controls. This is particularly true with respect to pharmaceutical costs where Medicare pays more for the same drug than other government administered health programs such as Canada's Medicare program.

Like Medicare, Medicaid was intended as a government financed insurance system that uses a private delivery system to provide healthcare goods and services. However unlike Medicare, administration of the program is devolved to the individual states. Medicaid enrollment is limited to the poor (mostly children) and disabled (individuals who have never worked). Funding predominately comes from a combination of state and federal funds. In the past, enrollees did not have to contribute to the cost of their care. However, recent expansion to the scope of the program via the State Children's Health Initiative Program (SCHIP) requires some enrollees to pay a sliding scale monthly premium.

In 2009, there were 60 million enrollees in the Medicaid program, almost half of whom are children. Total expenditures for the year exceeded $386 billion and constituted 2.7% of GDP.[24,25] Like Medicare, costs for this program have also continued to escalate. Here too, the lack of an integrated approach to healthcare financing has introduced inefficiencies such as healthcare dollars being diverted from the program to fund insurance company profits. In addition, the lack of a cohesive

focus also prevents the program from realizing additional cost savings from leveraging its purchasing power.

The governmental underwriting for this sector of the U.S. healthcare model is in fact deceptive. Neither the Medicare nor Medicaid fully funds the costs of the healthcare delivered to their respective enrollees. Both programs actually understate their true liability by paying providers less than the actual cost for the goods and services delivered. On average, Medicare pays 80% of actual costs while Medicaid pays 65%.[26] Providers make up this shortfall by skewing the rates charged to commercial payors and self-pay patients. This fiscal sleight-of-hand results in the commercial insurance sector paying 149% more than actual costs for services.[27] In turn, individuals enrolled in commercial insurance plans subsidize this Medicare and Medicaid cost shifting by paying more in premiums and out-of-pocket expenses.

Private Financing/Private Delivery Segment

In this segment, the underwriting of healthcare coverage comes from private sources (which may or may not be regulated) and is delivered through independent or contracted providers. These private sources consist of commercial insurers which pool and indemnify risks, employers and associations that self-insure, charitable organizations, individuals who pay out-of-pocket for premiums and care as well as a combination of all of the above.

Commercial health insurance is provided both on a group and individual basis. Group coverage is sold to employers and associations on behalf of their employees/members, while individual coverage is sold directly to the consumer. The cost of this coverage is dependent on the actuarial principle used to price or “rate” it.

"Experience rated" insurance utilizes the cost of prior paid claims for a group or individual to calculate future premiums. Thus, such insurance is much more costly for groups with older, sicker members than for groups with younger members who use fewer services. This insurance is also more expensive and more volatile in price for smaller groups due to the smaller size of the risk pool. "Community rated" insurance on the other hand, uses the total costs of prior claims for a given geographic area or across similar industries in order to derive the cost of group and individual coverage. The advantage to community rating is the stability of year over year premium due to the relatively large number of people paying into the collective fund which levels overall risk. Lastly, the cost of coverage is based on the scope of the benefits purchased.

Group coverage evolved as an employer and association sponsored benefit that grew out of social reform initiatives in the first quarter of the 20th century. Initially all health insurance was underwritten by commercial carriers who absorbed losses when medical costs exceeded premiums collected. Conversely, they pocketed the profits when premiums exceeded expenses. Over time however, large employer groups wanted the ability to have more control over the cost of health insurance. They began to self-insure their health costs by allocating company funds and employee contributions into a risk pool. These self-insured groups hired third parties to administer the fund and pay claims. Subsequent law and regulation fostered the growth of self-funded plans as well as the types of entities used to administer them.

According to 2008 census data, approximately 176.3 million Americans obtained their health coverage from their employers. This represented a drop of 1.1

million over 2007 enrollment figures.[28] While this year over year drop was exacerbated by the effects of a recession that began in late 2007, it is consistent with a steady decline in the number of Americans obtaining employer sponsored coverage. In 1999, 63% of Americans were covered by employer sponsored plans. By 2007 however, this rate had dropped to 59.3%.[29]

There are two factors contributing to the shrinking number of working Americans covered by employer-based plans. The first is due to a shift in the structure of the U.S. labor market. From 1977 – 1998 the number of unionized factory jobs decreased from 25% to 15% as more and more manufacturing moved offshore. The loss of union jobs also meant the loss of health coverage which had been a staple benefit to members of organized labor.[30] This trend has continued as the U.S. economy reconfigures from a manufacturing to a service centric one. However, the rise of the service sector has not been accompanied by the incorporation of health coverage as a workforce benefit. Thus while employment has generally grown, insurance coverage has contracted.

The second factor contributing to fewer Americans having health coverage is the increasing price tag to obtain it. From 1999 to 2009, premiums increased by 131%, while general inflation and employee wages grew by 28% and 38% respectively.[31] During 2009 when deflationary pressures kept the cost of other goods and services relatively flat, the cost of employer sponsored coverage nevertheless increased by 5%. The cost for family coverage currently averages $13,375 with the employee contributing $3,515 to the purchase of this coverage.[32] However if you add

out-of-pocket medical expenses to premium costs, the real outlay for coverage for a family of four in 2009 is approximately $17,000 - nearly 33% of median income.[33]

Factors fueling the escalation of costs within the private financing sector arise from external sources (i.e. fraud, public sector cost shifting, demand and new technology) as well as from model deficiencies (i.e. waste, misaligned incentives and structural inefficiencies). Waste is useless costs. It is the outcome of misaligned incentives and the structural inefficiency of the current model. For example, over-utilization of goods and services in this model segment occurs because of the interaction of consumer demand and provider incentive to generate income. Such over-utilization and waste contributes to the performance of approximately 20%-25% of medically unnecessary procedures each year.[34] The corporate underwriters of care (i.e. insurance companies and self insured groups/unions) seek to manage utilization by controlling processes rather than aligning incentives amongst the stakeholders. These underwriters have thus unleashed a complex, ever-widening array of policies and procedures in an attempt to regulate the provision and consumption of healthcare. However, the more they insert themselves into the clinical process, the more inefficiency and waste is generally created. Their army of nurses, doctors, reviewers and subcontractors try to control costs by manipulating access and payment. Services must be pre-authorized, concurrently evaluated, retrospectively reviewed and submitted for payment in highly proscribed ways. Providers have responded to these processes by constructing their own army of clinicians and administrative staff to try and wrest back revenue and clinical control. Countless hours and trees are consumed by the wrangling. In addition, the costs are additive as both providers and

underwriters each divert resources away from the delivery of healthcare. It is estimated that 20% – 30% of every healthcare dollar is currently spent on such overhead.[35] Billing costs alone are estimated to eat up more than $400 billion annually.[36] Efficiencies, and hence cost savings, could be introduced into the system via the widespread use of information standards, processes and certain technologies. Smart cards for instance could replace manual/paper process as well as better integrate clinical information exchange. However, the current structure of this segment of the healthcare model, with its free market belief in a broad supply of corporate underwriters, thwarts such efficiencies. This is because each underwriter is focused on short-term savings within their narrow market sector so as to generate investor return/profit. Thus, they are unwilling to fund the use of alternate processes or to subsidize new clinical paradigms which could yield financially and clinically superior returns in the longer term.

The evolution of the private financing segment of the U.S. healthcare model has resulted in a highly complex, fragmented, idiosyncratic and highly redundant means of providing indemnification for healthcare cost. Dozens of major, and hundreds of minor, insurance companies more or less perform the same tasks of marketing, enrollment, premium collection, claim payment and provider contracting. More than a half a million people are employed to support these processes. These companies have created a plethora of overlapping, duplicative provider networks that differ only in their branding. To maintain all these processes, the corporate underwriters generally retain 15%-20% of each premium dollar for general overhead, including profit. While the private financing sector is touted as a better way to pay for healthcare, the reality

is that the Medicare and Medicaid sectors are far more efficient as they spend only 3.6% and 6.8% respectively on overhead.[37] Ironically, in an effort to better control their healthcare costs, the private sector increasingly emulates Medicare's reimbursement structure as the basis for its own payment model.

Payment for healthcare in the private sector ultimately devolves down from the corporate underwriters to the small payors (i.e. employers and individuals) who pay the premiums. The eroding effect of increasing healthcare costs on company bottom lines however, has caused more and more employers to discontinue underwriting their benefit plan. Of the nearly 47 million Americans estimated to be uninsured in 2008, two-thirds were actively employed.[38] Pressure on corporate finances has also caused employers to shift a larger and larger proportion of the cost onto employees and/or reduce the scope of the benefit package. This pushes more employees into becoming uninsured as they are unable to afford the cost shift and thus forego coverage. Uninsured individuals and families however, cannot easily find a substitute for employer/group sponsored health coverage. Such coverage, if available, is purchased in the insurance spot market and is much more expensive than group coverage. It is also less extensive and frequently excludes coverage for certain diseases, conditions and subscriber classes. According to a 2009 report from the U.S Department of Health and Human Services, 12.6 million nonelderly Americans were denied coverage by commercial payers.[39]

Employees also become underinsured (i.e. covered by a plan that offers inadequate protection from healthcare costs) as a result of diminishment in the employer sponsored plan. This occurs when the employer replaces a sufficiently

comprehensive plan with one that has fewer benefits and higher out-of-pocket expenses. It also occurs when an employee selects a poorer benefit/higher co-pay plan when they are priced-out of the more comprehensive and more expensive options offered by their employer. In 2008, an estimated 50 million Americans were classified as underinsured.[40]

This segment of the U.S. healthcare model has morphed from a means of ensuring access to healthcare services into one that has formed a barrier to it. People with inadequate or no insurance coverage do not receive needed or appropriate medical care. This is because they are refused goods or services due to their inability to pay for out-of-pocket costs or because they do not seek care so as to avoid costs they cannot, and/or feel they cannot, afford. The doctor-patient relationship, as well as medication and treatment regimens, are disrupted amongst the uninsured and underinsured which results in discontinuous care and worse health outcomes. The data highlighting adverse outcomes among the uninsured are compelling:

- A study published in *The American Journal of Public Health* estimates that 45,000 deaths per year are associated with the lack of health insurance.[41]
- After adjusting for age, gender and education, the lack of insurance alone increases the risk of death by 25%.[42]
- The Robert Wood Johnson Foundation estimates that an American dies every 24 minutes due to the lack of medical care arising from lack of insurance.[43]
- An MIT led study reported that people without health insurance received 20% less care and had a death rate 37% higher than those with health insurance. This difference held up even when those without health insurance were

compared with those without auto insurance and those on Medicaid.[44]

The mortality rate in the uninsured/underinsured is driven in part by self-rationing, particularly with respect to preventive screening. People who are uninsured for example, are less likely to undergo screening for certain cancers. Thus, these cancers tend to be discovered when the disease has progressed and is more overt and thus less treatable/curable. Table 3 shows the results of a recent study which compared cancer screening rates between insured and uninsured adults in the U.S.

Table 3. Comparison of Cancer Screening Rates Among Insured Versus Uninsured U.S. Adults.[45]

Screening Type	Insured	Uninsured
Cervical cancer	90%	77%
Breast cancer	70%	52%
Colo-rectal cancer	50%	29%

While Chapter 2 will more fully explore the forces and events that have shaped the current underwriting model for financing healthcare in the U.S., one factor has remained salient over the course of one hundred years. That is, there has been consistent political, economic and cultural support for a market-based financing system. These supporters continue to promote and secure the continued entrenchment of corporate underwriting despite evidence that market competition has not resulted in a better product as defined by lower prices and better outcomes. The underlying problem is that traditional economic tenets do not apply in the healthcare market. For example, there is no counterbalancing demand for more sickness and the ill can't hold off purchasing healthcare goods and services until prices drop. Market forces don't appropriately apply themselves because the market has grown too imperfect. In a study involving forty-two states across the U.S., half of them had 70% or more of

their local markets controlled by the state's two largest for-profit insurance companies.[46] Such large, multi-state insurance companies wield a market clout that leaves consumers, local governments and providers with little leverage to redress predatory pricing or other market abuses. While the federal government is able to counter such market inequities, Chapter 2 will highlight how federal intervention withered whenever reform was cast by the insurance industry as socialized medicine.

CHAPTER 2

FROM THERE TO HERE: ONE HUNDRED YEARS OF IDEOLOGY, OPPOSITION, ECONOMICS AND INCREMENTAL REFORM

Overview

The current tri-segmented U.S. healthcare model evolved into its current form as a result of the interplay of political and social ideology, struggles for control of change as well as opposition to it, economic pressures and disjointed, piecemeal solutions to larger issues. It reflects the unique governance model of the U.S. with its checks and balances between the legislative and executive branches, as well as the tensions between federal and state power. It was also shaped by the American legacy of distrust of, and resistance to, expansion of federal power.

The origin of the U.S. model has a very different genesis from European models then evolving at the end of the 19th century. European countries for example had a strong legacy of "benefit societies" (England) and "sickness funds" (Germany) which protected members from the cost of illness and medical care. This in turn, facilitated a general mindset more predisposed to adopting health insurance on a broad scale. European countries were also geographically smaller and their populations more homogeneous than the U.S. Lastly, power was more concentrated in European civil governments than in the U.S. Such highly centralized governance reflected Europe's heritage of directive monarchial rule and thus accepted as a political norm. These factors enabled European governments to implement health insurance programs as a means to defuse social unrest, maintain economic stability,

accrue public loyalty and sustain political power. Germany implemented the first modern compulsory health insurance system in 1883. It was organized through independent sickness funds and applied only to wage earners. Other countries also initiated programs designed to protect workers from the economic effects of illness as detailed in Table 4.

Table 4. European Counties with Social Insurance Programs Around the End of the 19th Century

Country	Year
Germany	1883
Austria	1888
Hungary	1891
Norway	1909
Serbia	1910
Britain	1911
Netherlands	1913

U.S. Origins: 1900 – 1920

The American Association for Labor Legislation (AALL) was a prominent reform organization in the U.S. in the early 1900's. It initially advocated for enactment of programs that would protect the working classes from lost income due to illness or injury. However, it broadened this view by 1915 when it published a proposal to include direct payment for the cost of medical services. Such coverage was aimed at workers (excluding domestics and seasonal workers) earning less than $1200 per year. It also included their dependents. Cost of coverage was estimated at 4% of wages with employees contributing two-fifths, employers contributing two-fifths and the government contributing one-fifth of the cost. A typical worker earning $50 a month could expect to pay $.80 of the $2 monthly premium.[47]

The ability of the AALL to actualize reform was dependent on the degree of support it could cobble together from political, industrial and labor sectors as well as from the general populace. Unfortunately, the AALL's main political support came from the Progressive Party whose fortunes quickly went into decline after their presidential candidate, Theodore Roosevelt, was soundly defeated in the 1912 elections. Opposition also came from industry, which denigrated the AALL's efforts to introduce income stabilization (which at the time was a combination of what would now be described as workers compensation plus disability insurance) as they saw it as an incentive for worker malingering. On the other hand, organized labor wanted to block the availability of health insurance in the market so as not to lose a powerful union recruitment tool. Their efforts to defeat broad availability of health benefits was led by Samuel Gompers of the American Federation of Labor (AF of L) who sought to discredit reform and thus remove potential competition for worker loyalty. The American Medical Association however, was initially supportive of compulsory health insurance for both altruistic and self-serving reasons. Such insurance would reduce the financial risk to workers as well as ensure physician incomes. However, when the insurance model was redesigned to incorporate cost controls, physicians turned against it. The new model proposed replacing traditional fee-for-service reimbursement with a per capita payment based upon the number of patients who signed up with that physician for a fixed time period. Payment based on "capitation" was seen by physicians as a threat to their economic autonomy and it engendered a physician backlash against health insurance that lasted for several decades. Capitation

in fact, would not be proposed again as a payment methodology until the introduction of Health Maintenance Organizations as part of healthcare reform in the l970's.

Residual efforts to implement any kind of health insurance were nullified by outbreak of the first world war. In particular, anti-German political rhetoric portrayed the concept of health insurance as a socialist incursion and a subversion of American values. Popular opinion turned against health reform until social welfare issues could be reframed after the war.

While reformers were unable to introduce health insurance into broad acceptance, the private market was making major inroads with the working classes. Life and accident plans were available on a limited basis through immigrant beneficial societies and fraternal organizations. These plans covered the cost of the funeral as well as the expense of the illness or injury preceding it. Commercial insurance companies, such as Prudential and Metropolitan Life, recognized a market opportunity and began to offer "industrial insurance" plans directly to individual subscribers. However, the use of a direct sales model required deployment of a large broker force and intensive collection efforts in order to preclude payment default. Brokers would therefore station themselves at the factory gates on pay days in order to collect from the workers their weekly premium amounts of five, ten and twenty-five cents. In 1911, the total premium collected for such worker plans topped $183 million, an amount roughly equivalent to the German government's expenditure on its entire social insurance system for the same year.[48]

While direct marketing by insurance companies was successful, it was also inefficient as more than 60% of the premium was consumed by broker commissions

and other overhead.[49] Insurance companies therefore began to route the products through employers who would deduct the premiums from employee wages and send the consolidated payment onto the insurance company. This method offered a dual advantage in that it gave employers a means of attracting/retaining workers while increasing insurance company profits by reducing overhead. Thus was born the employer-sponsored insurance plan whose legacy now predominates as the largest source of private financing for health benefits.

From the 1920's to the Death of the New Deal in 1945

During the 1920's, the debate over the structure and financing of social insurance programs was largely dormant as the U.S concerned itself with post-war growth. However, concomitant to economic expansion was the growth in the cost of health care. At the close of the decade, national health expenditures had grown to $3.66 billion which represented 4% of GDP and a per capital cost of $30.[50] This was driven by two factors: (1) hospitals were evolving into bigger, more complex institutions offering more services, and (2) growth in physician specialization and the increasing monopoly power that devolved to them as a result of licensing restrictions on other provider types. Medical costs were now proportionately higher than lost wages during a given illness. For example, a family with an income under $1250 incurred a medical liability that was 20% greater than the amount of income lost from illness/injury.[51] Hospital costs now emerged as the largest component of acute care expenditures, a position it continues to hold today.

Once again, an independent reform movement sprang up with the intent to generate a framework for health insurance and to generate momentum to have it

implemented nationally. However the concept of health insurance had evolved and was now viewed by industry, reformers and the government as separate and distinct construct. It was no longer generally conflated with indemnification from workplace injury (soon to be known as workman's compensation), income replacement (unemployment insurance) and/or death benefit payments (life insurance). Instead it was seen as a stand alone means of protecting the subscriber and his/her beneficiaries from financial harm arising out of the costs incurred for the treatment of illness and accidents. The reformers launched a Committee on the Costs of Medical Care which was comprised of prominent economists, physicians and public health specialists. This think tank would operate simultaneously to, though independently of, governmental committees which were subsequently formed to examine similar themes. The Committee published its report in 1932 and hoped that it would serve as a catalyst for both public acceptance and government action for broad healthcare reform. The report attempted to define the scope of the country's total health care needs so as to enable the development of a national healthcare budget. The report promoted private voluntary health plans and the use of group health practices to administer services and achieve cost controls. Capitalizing on the roles that states had in providing for the welfare of their residents as well as their regulatory authority, the report also proposed that states be allowed to implement compulsory insurance enrollment. The AMA however was threatened by the report's advocacy of group practice models and the possibility of income controls if a national health budget was adopted. The AMA skillfully reframed the reformer's universalist approach and rational financing model as the specter of socialized medicine reborn. The negative

campaign waged by the AMA caused the Committee's report to be widely discredited. Concomitant ideological differences and loyalty conflicts within the Committee prevented it from mounting an effective retort to its critics and the organization imploded shortly thereafter.

The stock market crash of 1929 and the ensuing Great Depression resurrected the need for social safety nets. Franklin Roosevelt swept into the U.S. presidency with a "New Deal" that promised to use the resources of the government to address a broad spectrum of social needs. While he was interested in health insurance as part of the New Deal program, Roosevelt's primary focus was to provide income support for the unemployed and elderly. In June of 1934, he appointed the Committee on Economic Security (CES) to derive programs which would provide income protection to out of work Americans (i.e. unemployment compensation) and income security to the aged (i.e. a pension plan). The CES was headed by the Secretary of Labor, Frances Perkins, who expanded the Committee's charge to include the issue of health insurance.

The CES released a preliminary report in January of 1935 which outlined a nationwide health insurance program that would be administered at the state level. State participation would be voluntary although the federal government would provide subsidies to encourage them to participate. The federal government would set minimum standards for participating states ensure program uniformity.[52] (This presaged both federal/state cost sharing under the future Medicaid program as well as federally defined benefits required under 1970 HMO legislation). Physician autonomy would remain intact under the program as physicians would retain control

over procedures, personnel, patient acceptance, payment methods and whether or not to participate in the national insurance plan. Nevertheless, the AMA was vigorously opposed to the CES plan. Roosevelt was concerned that the furor over health insurance would jeopardize passage of the Social Security Act and he therefore quietly shelved the CES plan. No mention of health insurance was thus included in the Social Security bill that subsequently passed Congress in August of 1935.

Healthcare costs continued to be a concern for most Americans as the effects of the Great Depression wore on. Polls conducted in 1936, 1937 and 1938 reported that 75% of Americans felt that government should help in the payment of healthcare costs.[53] In July of 1938, Roosevelt convened a National Health Conference in order to review the nation's healthcare needs and potential financing methods. The AMA responded to the resurfacing of potential reform with a new tact. It now tried to control possible reform (especially compulsory insurance) by offering to support certain programs such as disability and indemnity insurance so long as these programs meet local Medical Society approval. The AMA was also amenable to expansion of public health and federal subsidies to cover healthcare costs for the poor. The National Health Conference however, yielded little of substance.

Three events now overtook healthcare reform. The first was the Congressional gains made in 1938 and 1940 by the Republican Party and conservative Dixiecrats who opposed further social initiatives. The second was the formal start of World War II in 1939 which refocused Congressional and Presidential energies on foreign affairs, U.S. defense and militarization. The third was Roosevelt's death in April 1945 which brought an end to New Deal initiatives.

It is ironic that the medical community, which was so opposed to health insurance initiatives during the 1920's and 1930's, would nevertheless father two enduring health insurance institutions during this period – Blue Cross and Blue Shield Plans. During the 1920's, there were two types of employer sponsored health coverage. The first involved the direct provision of medical services to employees through company owned facilities and employed doctors. Clinics and hospitals owned and run by mining companies typify this type. The second type of employer sponsored health coverage consisted of arrangements by employers to purchase indemnity coverage from commercial insurance companies on behalf of employees. In 1929, a teacher's union in Texas took elements of both insurance types and approached Baylor Hospital with the following proposal. The union would contract with this private hospital for a proscribed number of inpatient services to be provided to union members during the course of the year. Faced with empty beds and other overhead, Baylor agreed. This model was soon replicated by area employers with other local hospitals. It then spread to other locales around the country. The problem with this arrangement however, was that the number of employees covered under a given contract was often too small to offset the statistical risk of incurring a financial loss. In addition, employees faced limitations in both hospital choice and geographic accessibility to them. The solution to these deficits was to aggregate employees into larger pools so as to spread financial risk as well as to utilize a consortium of participating hospitals so as to allow for more choice. In 1932, the American Hospital Association endorsed the model which spurred national growth for this insurance model. By 1939, twenty-five states had passed legislation enabling not-for-profit

hospital corporations to be formed for the purposes of collecting premiums and assuming risks. Thus was born various hospital services corporations which become trademarked as Blue Cross plans. However, as these hospital service corporations essentially acted as insurance companies, they would eventually come under the purview of state insurance regulators who would oversee their underwriting and solvency. By 1945, more than 19 million Americans would have protection from hospital costs under a Blue Cross plan.[54]

Physicians also began to experiment with various risk arrangements during the 1920's and 1930's. Separate not-for-profit "medical services corporations" were established around the country to amalgamate risk, collect premium and disburse payment. These insurance corporations became trademarked as Blue Shield plans. While they operated under purview of the physicians who founded the plans, they were also subject to state insurance regulators who enforced underwriting requirements. Participation was open to all physicians on the condition that they accept payment at the Blue Shield reimbursement rate.

Some physicians emulated the early hospital model and amalgamated into group practices that contracted directly with employer groups and individual subscribers to cover the cost of medical services rendered by physicians. The AMA assailed these arrangements as the corporate practice of medicine and refused membership in the association to any physician practicing in this manner. This effectively blocked the formation of group practice associations as membership in the AMA was essential for a physician to gain hospital privileges and to obtain malpractice insurance. The AMA's anti-competitive actions however were later ruled

to be a violation of anti-trust laws by the Supreme Court in 1943. Nevertheless the growth and distribution of group practices was permanently hobbled by the AMA's assault. Group practices enjoyed a modest renaissance in the 1970's however, as early HMOs utilized them as the foundation for their delivery model.

Growth in Blue Shield insurance plans lagged behind that of Blue Cross due in part to their latter entry into the market and lower demand for the product. Thus, Blue Shield plans had only 2 million enrollees in 1945, just 10% of the enrollment in the counterpart Blue Cross plans.[55] The non-profit status of both Blue plans however, enabled then to allocate more premium dollar to medical care which was an attractive selling point. Nevertheless, the segregation of hospital and physician coverage into two unaligned plans left them at a market disadvantage when compared to commercial plans that integrated these components.

1945 – 1960: Entrenchment of a Two Tiered Financing Model

Polls conducted around 1945 indicated that a majority of Americans were once again favorably inclined towards a national health insurance program.[56] The new U.S. President, Harry Truman, also supported this concept and placed national insurance back on the domestic agenda following the death of Roosevelt. However, Truman bundled national health insurance into a broader health reform initiative that included funding for hospital expansion, grants for medical research and more government support for maternal/child health programs. In November of 1945, he called upon Congress to pass legislation that would protect Americans from the "economic fears of sickness".[57]

Congressional elections in 1946 however, returned control of Congress back to the Republican Party which was disinclined towards broad reform in general and national health insurance in particular. Truman countered Congressional resistance by incorporating the promise of national health insurance into his 1948 presidential campaign. His surprise victory in the election sent shockwaves through the medical community. Despite explicit reassurance that health reform would both protect physician autonomy and raise incomes, the AMA mounted an aggressive campaign to defeat national health insurance once and for all. They raised a million dollar war chest from special assessments levied against members and hired the pubic relations firm of Whitaker and Baxter to rollout a campaign to defeat Truman's plan. Once again, national health insurance was rebranded as "socialized medicine" and a threat to freedom of choice. The AMA's efforts, plus an undercurrent of national anxiety over the post-war expansion of communism, quickly eroded public support for health reform. Opinion polls conducted in 1949 showed that support among Americans familiar with the Truman plan dropped from 58% to 36%.[58] In a repeat of earlier scenarios, events on the international stage overtook domestic issues as the nation again girded for war, this time with North Korea.

The 1952 and 1956 national elections mirrored the re-emergence of a conservative mindset in the U.S. During the ensuing eight years of Dwight Eisenhower's presidency, neither he nor the Congress felt the need to develop a healthcare agenda. There were also no outside progressive interest groups trying to rally grassroots support for insurance reform like there had been in the first half of the century. In fact, such interest groups would remain relatively quiet until the 1990's.

Thus, it was left to the market to shape the delivery of, and the financing for, healthcare. The expanding economy during this period supported the growth of employer-sponsored health benefits which enabled more Americans to be protected from high medical costs. By 1958, two-thirds of the country had coverage for hospital costs.[59]

Congress however, did legislate incremental health insurance reform during the 1950's. This took generally took the form of amendments to existing programs. The most significant of these was a minor amendment to the Social Security Act that conversely would have a major effect on the current U.S. healthcare model. This amendment allowed for federal funds to be given as a match to state dollars to be used for direct payments to hospitals and doctors for services rendered to the poor. This had the effect of institutionalizing a system where there would be private financing of health insurance for the employed (and those who could afford to buy it) and publicly financed healthcare for the poor.

1960 – 1992: The Great Society and Subsequent Neo-conservatism

The social and political torpor of the previous decade was swept away in the 1960's by rising social tensions. The civil rights movement, anti-war protests, community activism and the development of youth counterculture generated an impetus for the government to take a more active role in social welfare. Polls again showed support for a national health insurance program especially among senior citizens who were beginning to coalesce as a political force. In addition, the AMA reversed its animosity towards a national insurance program as long as enrollment was voluntary in nature. Lastly, socially progressive Democrats were back in power.

The eventual reform bill was crafted in 1965 by Wilbur Mills who was the powerful chairman of the House Ways and Means Committee. The legislation he helped steer through Congress was a skillful compromise of competing interests. The first program, Medicare (whose name was copied from the Canadian health system) was designed to ensure medical benefits to the elderly and certain disabled citizens. It would consist of a mandatory “Part A” that would cover hospital expenses and a voluntary “Part B” that would cover physician services.

It would be funded from employee and employer contributions as well as by individual monthly premiums after the employee retired. The federal government would pool contributions and directly pay providers based on the government’s rate schedule.

The second piece of legislation, Medicaid, was designed to provide medical insurance coverage to those who didn’t qualify for Medicare. The Medicaid program thus covered children living in low income families, persons with disabilities and poor individuals who met income eligibility requirements. Medicaid was funded from pooled federal and state tax revenues although administration of the program devolved to the states. President Lyndon Johnson strongly supported these programs as emblematic of his “Great Society” vision. He signed these programs into law on July 30, 1965 and thus greatly expanded the government’s role in both the financing and the delivery of health care services.

The problem with both these programs however, was that reimbursement was structured on a fee-for-service model in order entice providers to participate. In addition, both programs underestimated the actual costs to deliver care which meant

that the initiatives were underfunded from inception. Compounding these financial flaws was an acceleration in the rate of health care inflation. In the five years after enactment of Medicare and Medicaid, health costs escalated at 7.9% annually versus a yearly rate of 3.2% for the prior seven years.[60] From 1965 to 1970, federal and state health expenditures increased from $10.4 billion to $28.1 billion or from $52 per capita to $133 per capita.[61] Public expenditures as percent of GDP almost doubled, rising from 1.4% to 2.7%.[62] These cost increases were being driven by a number of factors. One of the most salient, was the surge in the utilization of services particularly amongst Medicaid enrollees who now had broad access to medical care. In addition, the use of fee-for-service reimbursement generated a natural incentive for providers to perform excess procedures so as to increase income.

Pressure again mounted to reform the country's healthcare model. In 1970, two competing proposals soon emerged. Senator Edward (Ted) Kennedy called for the elimination of all private and public plans and to have them replaced with a single universal insurance program that would be administered by the federal government. Under this single payor system however, doctors and hospitals would remain independent. The Kennedy plan intended to control costs by developing a national budget and by streamlining administration. Congress though was not willing to implement such a radical reconstruction of the country's healthcare model and the plan was never put up for vote.

President Nixon, on the other hand, took an incremental approach that melded aspects of the liberals' healthcare reform agenda with the conservatives' desire to cut costs. In a speech on February 18, 1971, Nixon promulgated a national healthcare

strategy that would utilize an alternative insurance model to deliver better integrated and more cost effective services. Nixon's model had its roots in the integrated medical group practices/co-ops that emerged during the 1930's and which continued to operate in a few pockets around the country in the early 1970's. Soon to be widely referred to as a Health Maintenance Organization (HMO), Nixon's model would be offered along side traditional insurance though a person's employer. However HMO coverage would differ from traditional insurance plans in that enrollees would be required to use a network of HMO participating providers who would then "manage" the kinds and amounts of medical services the enrollee received. In addition, many providers would be disincented from performing unnecessary services since they would receive a flat prepayment (i.e. capitation) based on the number of HMO members in their patient pool. Thus, Nixon conserved the existing insurance framework while introducing incremental delivery and cost reform. To stimulate the growth of such managed care insurance plans, Nixon urged Congress to appropriate $45 million in grants and guaranteed loans to stimulate expansion of HMOs across the country.[63]

Enrollment in HMOs lagged however, until after passage of the federal HMO Act in December 1973. This Act laid out a relatively rich benefit package for all enrollees, specified annual open enrollment periods, barred exclusion of pre-existing medical conditions, preempted state laws banning prepaid plans and required that underwriting be based on "community rating" so as to moderate premium costs. Perhaps most important to HMO growth however, was the allocation of $375million in federal funds to seed new HMOs and the mandate that companies with more than

twenty-five employees offer this coverage if approached by a federally qualified HMO.[64] Lastly, evolution of the HMO model to include independent (nongroup) physicians in the provider network broadened market appeal.

The country still had a significant number of Americans without health insurance. Kennedy continued to push for universal coverage during the 1976-1980 presidency of Jimmy Carter. However, Carter felt that reform needed to wait until the economy recovered from the recession precipitated from manipulation of global oil supplies by OPEC countries. In Carter's view, reform would simply impose another drag on the economy. Kennedy countered by proposing a new plan that would use the private system coupled with incentives to gain national costs savings. This in turn would spur the economy and thus cover any marginal costs that universal coverage would incur. These fundamental differences in vision however, resulted in healthcare reform efforts becoming stalemated.

A shift in political mood brought neoconservatives into power starting with Ronald Reagan's presidency from 1980 to 1988. This was followed by the election of his vice president, George H. Bush, to the top slot from 1988 to 1992. Reagan felt that government intervention impeded the market's ability to regulate and optimize itself with respect to healthcare services and protection from such costs. He therefore sought to shrink the federal government's role by reducing oversight and scaling back and/or capping expenditures. His efforts resulted in funding for federal health programs being consolidated into lump-sum "block grants" that devolved to the states. Each state was then free to allocate grant monies in accordance with its own priorities. The neoconservative agenda also stimulated Congress into passing other

healthcare cost controls. Caps on Medicare spending were introduced and reimbursement to providers was reformulated. Some services would now be bundled and paid at a lesser "package rate" while other payments would be adjusted depending on the intensity of the service. Neither Presidents Reagan and Bush nor Congress, dealt with the fact that Medicare and Medicaid payments were priced less than the actual costs to provide services to their respective enrollees. As a result, government financed underpayments continue to be passed onto the private sector.

The neoconservative confidence in the power of competition in the healthcare market to derive the optimal solution is based on a misplaced assumption that the market operates relatively perfectly. In fact, the healthcare market is largely unaffected by normal supply and demand forces. For example, there is no demand for sickness and consumers cannot wait for health insurance prices to drop before buying coverage. In addition, the market has been allowed to become extremely skewed due in large measure to the immunity from federal anti-trust law that insurance companies have enjoyed for decades. Thus, many consumers have had increasing exposure to steep premium increases, coverage denials, higher out-of-pocket expenses and few options for other coverage. This skewing is exemplified by the recent announcement by California's largest health insurer, Anthem Blue Cross, of its intent to raise its premium in early 2010 by 39% despite the fact that the CPI for all of 2009 was only 1.3%[65]

1992 – 2010: What's Old is New Again

President Bill Clinton, a Democrat, came into office in 1992 committed to reintroducing healthcare reform. He appointed his wife to head a committee to

develop a comprehensive framework for universal coverage. Medicare and Medicaid however, would be excluded from the plan. The resultant 1,000 page proposal produced by this quasi-government committee retained the mixed model of private and public financing segments. Employers would be mandated to provide health insurance to all employees which would be financed by payroll taxes. The government would pay for coverage for nonworking Americans. Care would be delivered through HMOs who would be vetted by regional healthcare alliances so as to ensure competition, choice and fairness. Employers and individuals would be free to select from the list of HMOs in their area. Unfortunately, the use of an independent committee to craft a legislative blueprint generated protests from both the external interest groups who had felt left out of the process, as well as from the members of Congress who felt that their role had been usurped. As a result, the Clinton plan was dead not only for the remainder of his first term, but for his second as well. Nevertheless, a major advance in healthcare coverage was enacted during the Clinton presidency – the State Children's Health Insurance Program (SCHIP). This reform would serve to cover millions of uninsured children whose families were not quite poor enough to qualify for the free Medicaid program but who were also not affluent enough to be able to afford commercial coverage. Originally introduced by Senators Ted Kennedy and Orin Hatch as part of the Balanced Budget Act in May of 1997, it was initially defeated by Republican opposition and the failure of the Clinton White House to throw its support behind it. Nevertheless, both senators reintroduced the bill and it was signed into law on August 5, 1997. The law piggybacked onto the existing Medicaid program by raising the income limits under which families could qualify for

the program. It also simplified the Medicaid enrollment process and provided incentives to states to institute robust outreach programs. The program currently covers seven million children and is administered at the state level.[66] It is jointly funded by the states and the federal government though tax revenues imposed on cigarettes.

George W. Bush (son of former president George H. Bush) assumed the Presidency in 2000 and again in 2004. These elections marked the resurgence of the neoconservatives and also restored control of Congress to Bush's fellow Republicans. The second President Bush was also opposed to the kind of government activism that he and fellow neoconservatives viewed health reform as representing. In addition, much of his focus was preoccupied by the after effects of the 9/11 attacks and the subsequent retaliatory wars in Iraq and Afghanistan. Nevertheless with the presidential elections looming at the end of 2003, Bush supported a move by fellow Republicans to amend the Medicare program so as to improve its solvency. The highlight of the revised program was the creation of a prescription drug benefit (i.e. Medicare Part D) which would serve to woo senior citizen voters to the Republican Party in the fall. While Bush and Republican leaders were criticized for deliberately understating actual costs of the drug program by hundreds of billions of dollars, and thus repudiating their avowal of fiscal responsibility, their strategy proved a successful one. The newly re-elected President Bush subsequently signed the Medicare Modernization Act into law on December 12, 2003.

In his successful 2008 bid for the Presidency, Barack Obama made revamping the financing and availability of healthcare a core component of his reformist

platform. He proposed universal coverage for children using expansion of the Medicaid program as well as mandated coverage under a parent's health insurance plan. In addition, a new non-profit public insurance plan would be created. The public plan and all approved private plans would be available through newly created national and/or regional insurance exchanges. Individuals and employers would be free to select from any of the plans listed on the exchanges, thus encouraging private plans to compete on the basis of cost, quality and scope of benefits. These exchanges would generate significant costs savings over the current insurance model as it would eliminate overhead now incurred through broker commissions, sales staff and enrollment processes. The uninsured would be assisted in acquiring health insurance through federal subsidies based on their income level. Large employers would be required to provide insurance coverage to their workers or pay into the government's subsidy fund. Lastly, no one could be denied coverage due to their medical history.

Obama's plan however, represented only mild reform. It left in place the same tri-segmented model that already existed. The insertion of the a "public option" and the creation of insurance exchanges do little to amend the fragmentation in the financing and delivery of healthcare in the U.S. Its greatest impact would be on the privately financed/private delivery segment of the model as the lower cost of the public option could cause individuals to migrate into the publicly financed/private delivery segment. The Lewin Group estimates that for every 1% reduction in premium that the public plan represents over a private plan, 2.47% of enrollees in that private plan will switch over to the public plan.[67] Depending on the premium differential used in the calculation, anywhere from 20.6 million to 119 million

enrollees would out-migrate from the current private insurance pool of 180 million enrollees.[68]

While President Obama provided the framework for health reform, he intended for the legislative process to negotiate the details. He was not going to repeat President Clinton's mistake of handing Congress a fully formed bill that would get torn apart by internecine conflict. Instead, Obama focused on crafting a budget to support reform costs. He also sought to preclude mistakes made by his predecessors with key stakeholders in the medical and insurance sectors. He therefore held a series of roundtables with such stakeholders as the AMA, the American Hospital Association, labor groups and the American Association of Health Plans so as to secure their buy-in to cost controls and reform. He was thus able to blunt opposition efforts that had imploded other reform initiatives.

In his February 2009 budget address, President Obama proposed that $634 billion be set aside over ten years to fund health reform initiatives. He stressed the need for urgent action given the threat that escalating healthcare costs posed to the country's economic security. He proposed funding the program via a combination of targeted tax increases and savings wrung from current health programs. In particular, he projected generating $318 billion from new taxes imposed on the wealthy, $175 billion from ending payment differentials to private insurance companies offering Medicare Advantage plans, $37 billion from home healthcare cuts and $20 billion from imposed discounts on Medicaid pharmacy costs.[69]

A flurry of legislative initiatives were soon under review by several key Congressional committees by late spring 2009. House efforts were led by the Energy

and Commerce Committee, chaired by Henry Waxman; the Ways and Means Committee, chaired by Charlie Rangel; and the Education and Labor Committee, chaired by George Miller. The Senate's efforts were driven by the Health, Education, Labor and Pensions Committee (chaired by Ted Kennedy/Chris Dodd) and the Senate Finance Committee (chaired by Max Baucus). Initial optimism that bills would be ready for floor vote by July 4th was soon dashed by myriad objections raised by Republicans as well as opposition from the Democratic conservative faction known as the "Blue Dogs". Throughout the summer and early fall of 2009 the various Committees were forced to retool their bills in an effort to produce passable legislation.

Reform legislation was finally introduced into the House on October 29th, via the "Affordable Health Care for America Act" (H.R. 3962) and was subsequently adopted nine days later by a narrow five vote margin. The Act contained several key elements of the original Obama plan including a government sponsored insurance option, an expansion to the Medicaid program, creation of health insurance exchanges and a mandate for employers to provide/fund health insurance benefits.[70, 71] The Act however banned coverage for abortions using public funds and placed strict limits on how private plans could offer this coverage. While the CBO estimated the cost for the benefits and obligations created by the Act to be $891 billion over ten years, it would nevertheless reduce the national deficit by $138 billion.[72] The legislation was sent to the Senate on November 9th where it proceeded to languish. In fact, the Senate does not take action on the bill until late Spring 2010 when it is amended into a completely different piece of legislation and given a new title.

Instead, the Senate utilized the "Service Members Home Ownership Tax Act of 2009" (H.R. 3590) which had just passed in the House on October 8th as the vehicle for crafting the upper chamber's reform bill. Using its committee review and amendment process, the Senate completely guts the House's version of the Act and renames the bill the "Patient Protection and Affordable Care Act". The resultant bill omits Obama's desire for a public option as well as the mandate for employers to provide insurance coverage. However, it did preserve several aspects of the Obama plan including the creation of insurance exchanges (one for each state), subsidies/tax credits towards insurance costs and the expansion of Medicaid coverage to include individuals and families earning less than 133% of the federal poverty limit. The most contentious issue in the bill was the last minute exclusion of abortion coverage as a basic benefit.

The CBO estimated that provisions in the Act would cost $8758 billion over ten years while simultaneously decreasing the deficit by $118 billion over the same period.[73] The Democrats successfully passed the Act on December 24, 2009 by using their supermajority to override Republican objections 60 to 39 (with one Republican abstention).[74]

While the House's "Affordable Care for America Act" and the Senate's "Patient Protection and Affordable Care Act" shared many of the same provisions, they were still two different pieces of legislation. Normally, such differences would be resolved using the ad hoc Conference Committee process. This Committee is comprised of select members the House and Senate who blend the two bills into a single revised piece of legislation that can go back to both chambers for approval.

The Democrats however, were precluded from pursuing this route when a special election was held in Massachusetts on January 19, 2010 to fill the Senate seat of late Ted Kennedy's Senate. In major upset, the seat was won by a Republican. The election of the anti-reformist Scott Brown had a profound effect on Senate dynamics as it shifted the balance of power towards the conservatives. The Republicans now had 41votes and could employ a filibuster to effectively block passage of any compromise reform bills drafted by the Conference Committee. On the other hand, with only 59 votes left to them, the Democrats were now one vote shy of the necessary supermajority needed to thwart use of the filibuster tactic.

The political shift seemed to leave the Democrats off-balance and uncertain as to the future of reform. President Obama, however, used the State of the Union address and subsequent campaign-style cross-county stumping to reinvigorate the reform movement amongst Democrats. By early March 2010, Democratic leadership had coalesced around a plan wherein the House would abandon its reform bill and instead adopt the Senate's "Patient Protection and Affordable Health Care Act". This approach outmaneuvered Senate Republicans as this bill had already been passed by the upper chamber. Success in the House however, depended on the Democrats' ability to hold their coalition together. While there were enough Democrats in the House to pass the Senate's bill, a number of them balked at supporting the measure as it lacked several key provisions that the House had included in its original "Affordable Health Care for America Act". To entice these House members to adopt the Senate's version, a follow-up piece of legislation was promised which would "fix" the Senate's "Patient Protection and Affordable Care Act" by adding back in

certain desired provisions from the discarded "Affordable Health Care for American Act". This compromise was accepted and the House approved the Senate's measure on March 21, 2010 by a vote of 219 – 212.[75] The Act was subsequently signed into law two days later.

The proposed 'fixes" bill however, would surely succumb to a Senate filibuster if passage was attempted using the conventional process. To avoid this pitfall, Democrats opted to use the reconciliation process as it limits the amount of time for Senate debate and requires only a simple majority vote to in each chamber to pass the measure. Ironically, it was the Republicans that enabled Democrats to employ this tactic. In 1996, the Republicans broadened the reconciliation process from being a means to facilitate passage of omnibus budget resolutions to being one that could apply to any revenue or spending bill.

Democrats still needed to tread carefully as only one reconciliation bill may be passed each year and its provisions must directly relate to the budget. Democrat control of the rules process ensured that the reconciliation bill would pass in the House. However, passage in the Senate was not so guaranteed. The Senate's Byrd Rule (named after the late Senator Robert Byrd) allowed any Senator to object to any reconciliation act provision seen as incidental to the budget and thus potentially derail passage. Fortunately for the Democrats, the CBO estimated that while the new bill would increase spending by $60 billion, it would ultimately reduce the federal deficit by $124 billion over ten years and thus meet budget objectives required under the reconciliation process.[76, 77]

The “fixes” bill was introduced on March 18, 2010 under the title the “Health Care and Education Reconciliation Act of 2010” (H.R. 4872). It was a hybrid bill that not only amended the “Patient Protection and Affordable Care Act” as promised, but also included a last minute incorporation of federal student loan program reforms. The House quickly passed the measure March 21, 2010 by a vote of 220 to 211. In the Senate however, Republicans futilely proposed 165 amendments in an effort to defeat the bill. While they did manage to strip out two education provisions using the Byrd rule, the bill was ultimately passed on March 25, 2010 by a vote of 56 to 43. As a result of these changes, the amended reconciliation bill had to be sent back the House for approval. The House approved this amended version the same day by a vote of 220 to 207 and the bill was signed into law March 30, 2010.[78]

The new laws introduced the most significant change to the scope and means of providing insurance coverage to Americans since the enactment of Medicare and Medicaid in the 1960’s. They embody a commitment to near universal health insurance coverage by enabling thirty-two million uninsured Americans to obtain benefits thereby raising the proportion of Americans covered by insurance to 95% by 2019.[79] The laws further expands the role of states in administering insurance options, provides for federal subsides to support the broadened scope of Medicaid plans, utilizes tax credits and financial penalties to promote employer sponsored health coverage and seeds development of new insurance models such as Co-Ops. In addition, the laws are innovative in their commitment to improve healthcare quality and wellness promotion. They explicitly require the use of performance metrics which reward providers of quality, cost effective care while penalizing those who fall

short. Lastly, the new laws set forth a revised framework for pooling risk and ensuring certain consumer protections as detailed in Table 5.

Table 5. Additional Provisions of the Health Care Reform Acts of 2010

- Establishes insurance exchanges in each state with standardized benefit categories
- Establishes national risk pools to provide insurance coverage to individuals with pre-existing medical conditions
- Expands dependent coverage to include adult children up to age 26 for individual and group policies
- Prohibits lifetime dollar limits for the cost of services
- Prohibits coverage rescission except in cases of fraud
- Prohibits exclusions for children and adults with pre-existing conditions
- Requires insurers to rebate premiums to consumers if less than 85% of premium for large groups and 80% for individual subscribers is actually spent on health services
- Creates an oversight process for premium increases

It should be noted, that many of the reforms will be rolled out over the next four to ten years, during which time, opponents will have the opportunity to potentially overturn some or all of the law's provisions. In addition, much of the law will need to be encoded into regulation which provides further opportunity for special interest groups and opponents to mitigate or skew the law's effect.

While the new law advances health reform, it is nevertheless much less than the dramatic system overhaul that it is touted to be. The U.S. still retains its current mixed model consisting of a government financed/government delivery system, a government financed/private delivery system and a privately financed/private delivery system. The only real difference is the degree to which the privately financed segment is now overtly subsidized by tax breaks and government payments given to individuals to buy private insurance. This produces a blurring of the line, but not an elimination of it. The second difference is an expansion of the government financed/private delivery segment. Here too, there is no fundamental change, but rather an enlargement of scope as more people become eligible for government programs. Instead of adopting a new paradigm based on healthcare models of other countries, the U.S. has again stayed the course of modifying the underlying status quo.

CHAPTER 3

COMPARATIVE MODELS OF HEALTHCARE FINANCING AND DELIVERY

Overview

Like the United States, other highly developed countries have faced the issue of providing for the welfare of its citizens. As in Maslow's hierarchy of needs, these countries have first attended to national sovereignty and its defense, then to the sustenance of its economy, and then to the well-being of the population. However unlike the U.S., other countries have recognized the correlation between economic health and the health of its citizens and have moved decisively to create a healthcare model that serves both needs under a common rubric. These models reflect the cultural norms and histories of each country and therefore are distinctly varied from one another. However, they all share a thread of commonality. That is, they all share direct government intervention in the creation of a healthcare model based on universal, rationalized access, equitable funding and the unifying vision that such healthcare is an individual right.

Germany: The Bismarck Model

The current German health insurance model traces its legacy to the sickness funds ("Krankenkassens") first established by guilds, trade groups, benefit societies and certain industries for the welfare of their constituencies. These funds paid for lost wages and the cost of medical expenses incurred as a result of injury or illness. German's autocratic Chancellor, Otto von Bismarck, co-opted the social welfare model established by these funds as a means to preempt the power of the rising

Socialist Party which was threatening to destabilize both the German monarchy and government. The Socialists recognized the growing discontent within the working classes with respect to both political rights and economic protection. They sought the support of these classes in setting up a new political order which would address economic and social inequities. Bismarck responded by banning the Socialist Party but precluded social unrest by implementing the Accident Insurance Law (workers compensation) and the Sickness Insurance Law (health insurance). The latter Act created a national health insurance program with mandatory participation and thus formed the foundation for the model in effect today.

The eighty-two million citizens (and guest workers) covered by Germany's modern Sickness Funds enjoy a rich benefit package, wide access to services and few out-of-pocket expenses. While the government mandates the basic benefit package components, competition amongst the nearly 200 not-for-profit sickness funds ensures innovation, cost effectiveness and enriched benefits offerings. For example, the Sickness Funds cover physician, dentists, chiropractic, optician services as well as the costs for pharmaceuticals, nursing homes, other therapies and health club memberships. Sickness Funds may not refuse coverage to anyone in the areas they are approved to operate.

Participation in the Sickness Funds is mandatory except for upper income Germans (approximately 7% of the population) who are allowed to secure their coverage from for-profit insurance companies.[80] The Sickness Funds are financed jointly by employees and employers from payroll deductions. Premium costs consume approximately 15% of salary which is roughly equivalent to what

Americans pay in Social Security and Medicare payroll taxes.[81] However, there are ceiling maximums for Sickness Fund deductions. Employers serve only as the conduit for premium collection and do not govern employee choice of which fund they may participate in. As a result, coverage is linked to the employee who can take the coverage with them if they change jobs. In the event a worker becomes unemployed, the government pays the entire Fund premium.

The German health delivery system is robust and access to services is timely. Physicians are paid on a fee-for-service basis though their incomes per specialty are generally significantly less than similar specialists in the U.S. The German hospital system consists of not-for-profit municipal and charitable institutions although there are some for-profit clinics and hospitals that cater to the privately insured. Reimbursement is based on a regional fee schedule that is derived from the negotiations between the consortium of Sickness Funds and the area's providers. Other than for very minor co-pays, Germans have no out-of-pocket expenses for their health care.

The German health care system is the second most expensive in Europe consuming approximately 11% of GDP.[82] Upward pressure on health costs is being driven by more expensive technology and increased utilization. The government has therefore implemented a number of cost controls in recent years. These include the use of physician gatekeepers who determine whether a referral for further services is warranted, the use of regional fee schedules, use of smart cards to improve system efficiency and the introduction of patient co-pays. Most recently, the German Health Ministry has allowed Sickness Funds to use global budgets when underwriting

healthcare costs. If the Fund becomes exhausted for a given period, providers are still required to render care and may not bill the patient for the costs of the services.

Great Britain: The Beveridge Model.

The forerunners of the current British healthcare model were the "Friendly Societies" and independent sickness plans. Friendly Societies were national organizations set up by trade, artisan and labor groups to provide social welfare benefits for their respective members. Indemnification from economic loss arising from illness or injury was a prime benefit. Workers could also purchase health insurance from voluntary sickness funds. These commercial plans covered 13% of the British workforce in the early 20th century.[83] These programs were subsequently absorbed into social welfare initiatives implemented after the end of World War II. As the war was winding down, England prepared to transition from a militarized economy to one focused on domestic affairs. Partially motivated by the Labor Party's desire to hold on to working class political support and partly as a result of national reconstruction needs, the government sought to develop and implement a number of revitalization programs. A Committee on Social Insurance and Allied Services was appointed by Winston Churchill to draft recommendations for social reform. Under the leadership of its socially progressive chairman, William Beveridge, the Committee's report contained a proposal for the creation of a unified, government-run health system. The National Health Service, as it was called, would be universal in scope and funded out of general taxation. The model was adopted by Parliament on July 5, 1948.

The present National Health Service (NHS) has expanded and refined Beveridge's concept. The NHS owns and operates 2,000 public hospitals across the country and is Europe's largest employer with over one million full-time staff.[84] Specialty physicians are salaried employees of NHS although they may see patients privately in their off-hours and collect fee-for-service payments. Primary care physicians however are all independent practitioners. They are paid on a capitated basis but may earn up to $125,000 in quality incentive payments depending on how they score against national "best practice" benchmarks.[85]

Participation in the NHS is voluntary, but nine out of ten citizens do.[86] There are however, private for-profit insurance plans available to individuals wishing to opt out of the NHS. All healthcare services under the national plan are covered at 100%. There are no out-of-pocket expenses except for some adults who may have pharmacy co-pay amounts. As the NHS is a single payor system, there are virtually no bills generated.

The NHS comprises the bulk of national health expenditures in Great Britain. In 2005, these expenditures equated to 8.2% of GDP, considerably less than the U.S. rate of 15.4% of GDP for the same period.[87] The NHS gets its funding through sales taxes, currently running at 15% -17.5% as well as general income tax revenues.[88]

Rising health care costs are countered in two ways under the NHS. First, the government will not pay for services that the National Institute for Health and Clinical Excellence (NICE) deems as not medically necessary or cost effective. The second is the rationing of healthcare that is generated by potentially significant wait times (the "queue") to see specialists, undergo testing or treatment. However recent

increases in funding under the Blair government has significantly reduced wait times for elective services and virtually removed them for acute care services.

French Model

The French have constructed their healthcare system around the value of solidarity (solidarité). They have borrowed elements from the Bismarck model (e.g. use of private sickness funds) while still crafting a uniquely French system (e.g. unionized physicians) to serve its sixty-one million citizens. The French healthcare system has been arguably called the best in the world when measured in terms of fairness, accessibility, affordability and health outcomes. On a per capita basis, France has more hospital beds and physicians than the United States.[89] In addition, they utilize physician services more frequently than U.S citizens and also have longer lengths of stay in the hospital.[90]

All French citizens are required to purchase basic coverage insurance from one of eleven insurance plans. No one may be denied coverage, although eligibility for a specific plan is largely predetermined by a person's occupation or geographic region. The three main health plans serve specific sectors: one covers salaried workers, the second covers farm workers and the third covers professionals and the self-employed. Workers in certain industries, along with individuals excluded from one of the main plans, are covered by one of eight smaller plans. The cost for basic insurance is very low and premiums are deducted directly from worker salaries. Both workers and employers contribute jointly to the cost of the premium, though employers contribute proportionately more. A typical worker earning $20,000 a year would have an average monthly premium of $220.25 of which $12.25 would be allocated to the

worker and $208 to the employer.[91] People who lose their job retain the same coverage they had except that the employer contribution is now paid by the government.

The French government dictates the generous scope of benefits offered in a basic health insurance plan. Nevertheless, 90% of the population elects to purchase supplemental insurance from either for-profit insurance companies or co-operative health plans.[92] This additional coverage is very inexpensive and pays for services, pharmaceuticals and certain out-of-pocket expenses not covered by the basic plan.

French citizens are entitled to see any physician they choose and to be treated at any clinic or hospital in the country. Insurance plans are required to pay in full for all services defined in the benefit package. While patients pay a fee at the point of service, they are fully reimbursed for this out-of-pocket expense by the insurance company within a few days. All fees are waived for the poor and chronically ill.

Physicians and hospitals in France are reimbursed on a fee-for-service basis in accordance with a national fee schedule. All rates are published and patients have access to them. The rates are derived from negotiations between the physician unions and the French Ministry of Health acting on behalf of the insurance plans. The government has kept a relatively tight grip on fee schedule increases which in turn has constrained physician incomes. French physicians therefore earn one-fourth as much as their American counterparts.[93] Not surprisingly, French physician unions have staged demonstrations to express their discontent over the rate setting process.

France has tried a number of measures to adequately control health care inflation. Structurally it utilizes not-for-profit insurance companies so as to maximize

the percent of premium available for direct health care. Operationally, it has incorporated electronic data interchange into healthcare administration to induce efficiency and cost savings. For example, all French citizens are provided with encoded *Carte Vitale* (smart insurance ID cards) to facilitate medical information tracking and billing processes. Strategically, the French have set spending targets to hold down deficits. Nevertheless, from 1996 to 2006 the healthcare deficits doubled to $69 billion.[94] While the percent of France's GDP consumed by health expenditures stood at 10% in 2006, this rate paled in comparison to the 15.8% of GDP for the US for the same period.[95]

Canadian Model

The metamorphosis of the Canadian model is unique in that in was a regional innovation that spread nationally. In 1944, Thomas Douglas successfully campaigned for the governorship of Saskatchewan on a promise to implement free health care to residents of the Province. He was familiar with the Beveridge model and borrowed from it the concept of a government administered and publicly financed health system. His plan differed from the Beveridge model however, in that it utilized a private delivery system and covered only hospital costs when it became operational in 1947. Douglas spearheaded expansion of the Saskatchewan program to include coverage for physician services in 1962. He dubbed the newly integrated program "Medicare".

The success and popularity of the Saskatchewan program prompted the Canadian government to foster its replication in other sections of the country. In 1957, the federal government passed the Hospital Insurance and Diagnostic Services

Act which provided matching funds to the provinces and territories to cover hospital costs. It followed this up in 1966 with enactment of the Medical Care Act which shared the costs of physician services between the federal and provincial governments. By 1972 all provinces and territories had publicly financed health plans offering universal access to hospitals and physicians free of charge. Each province and territory administered their own plans which included enrollment processes, provider fee negotiation, premium collection, claim payment and benefit design. This engendered regional variations between plans which still persist today.

The country's egalitarian values are reflected in the health system. All citizens are covered regardless of employment status, income or their state of health. Public financing is raised through federal and provincial taxes. In addition, some provinces charge a monthly premium for the plan. The federal government retains some taxes to cover the programs it directly administers (i.e. military personnel, prisoners, Inuit and First Nation peoples) and apportions the rest back to the provinces and territories. Initially these payments represented 50 -50 matching funds. However since 1977, the federal government switched to the use of block grants which have been generally insufficient to cover the cost of services. This results in the provinces and territories having to make up any shortfalls out of their budgets. In the funding year 2008 - 2009, the federal government transferred $22.6 billion back to provincial and territorial health plans.[96] While public sources make up 70% of total health expenditures, out-of-pocket contributions constitute 15%, private insurance comprises 12% and social insurance makes up the remaining 3%.[97]

There was concern in the 1970's that Canada's egalitarian health model was devolving into a two-tiered system due to the practice by physicians and hospitals of directly billing patients for their services and thus bypassing government plans. The federal government responded to this situation by enacting the Canada Health Act in 1984. This law codified the guiding principles of the nation's health plan and laid out the criteria of comprehensiveness (provinces must provide medically necessary hospital and physician services); universality (open to all residents); accessibility (reasonable access to care and without financial barriers); portability (out-of-area coverage) and public administration (operated on a non-profit basis by a public authority).

Canadians are free to purchase supplemental private insurance to cover health care services and/or pharmaceuticals that are excluded from the government sponsored plan. The premiums are relatively inexpensive since the government plan is a fairly comprehensive one. Approximately 65% of Canadians opt for private coverage, many of whom get it as a benefit from their employer.[98] Private insurance plans have been explicitly barred from offering benefits that replicate those in the government sponsored plan. However a 2005 Canadian Supreme Court ruling has overturned part of this ban.

The Canadian system is an overtly rationed system. The Canadian Coordinating Office for Health Technology and Assessment determines which services and technologies are appropriate and effective, and thus payable. Funding for medical education is also predetermined so as to control supply. Other rationing is implemented on the provincial level through global budgets paid to hospitals and

through fee schedule payments to physicians and other providers. These rationing methods have allowed the Canadian system to keep much tighter rein on health care inflation than the U.S. Nevertheless, national expenditures on health services totaled $172 billion in 2008, a 102% increase over the $85 billion spent in 1998.[99] However if the impact of population growth, aging and inflation are subtracted out, the net increase in spending over the last ten year is 49%.[100] According to the Organization for Economic Co-operation and Development, Canadian per capita health spending in 2008 was $5,170.[101]

However, rationing has taken its toll on medical infrastructure and availability. This has manifested itself in significant wait times for surgical procedures, specialty consultations, diagnostic and imaging procedures and therapeutic services such as radiation treatments. A 2005 study conducted by the Canadian think tank, the Fraiser Institute determined that 85% of median wait times were higher than clinically reasonable.[102] Over the last several years, the Canadian government has invested over $5.5 billion to reduce wait times and improve access.[103] In addition, Canada's health ministers established wait time benchmarks for five important medical procedures to ensure uniform improvement in service access. As a result of these efforts, 75% of patients now receive treatment for the five targeted services (i.e. cancer radiation, coronary artery bypass surgery, hip replacement, knee replacement and cataract surgery) within established wait time benchmarks.[104]

CHAPTER 4

UNFINISHED WORK: THE NEED FOR A NEW PARADIGM

The enactment of the Patient Protection and Affordable Care Act and the Heath Care and Education Reconciliation Act has hardly put an end to the health reform debate. Republican opponents of the reform laws are planning to make the Acts an issue in the upcoming November 2010 and 2012 elections. They hope to leverage potential gains in the House and Senate to reverse, moot or mitigate many of its provisions. In addition, thirteen State Attorneys General have aligned against the Acts claiming that they violate States' rights. They have filed suit against the federal government in an effort to have the legislation struck down on constitutional grounds. These modern gambits however, represent yet another phase in a one hundred year struggle to derive a suitable model for the delivery and financing of healthcare in America.

The new law leaves much of the current fragmented, wasteful and costly system unaltered. It does however, introduce some important incremental improvements. These improvements include: guaranteed access to insurance (e.g. plans must accept all applicants, no exclusions for pre-existing conditions); protection from coverage loss (rescission is banned, no lifetime payment caps); financial assistance (tax credits, premium subsidies); and broader coverage choice via newly created insurance exchanges. On the other hand it introduces complex standards for determining premium subsidies, eligibility to purchase coverage through the exchanges and penalties for noncoverage. Lastly, it leaves in place misaligned incentives, cost shifts

from the public to the private sector and structural inefficiencies that will waste billions of dollars.

What has prevented the U.S. from embracing the kind of comprehensive reform that other developed countries have implemented? For example Switzerland converted to a Bismarck-like model in under two years, while Taiwan converted their system into a unique universal model in less than a year. The answer of course is a mutifactorial one that reflects differences in governance structures, political processes and cultural values. The innate characteristics of the parliamentary systems in Great Britain, Canada, Germany and France (even given the hybrid properties of the French presidential/parliamentary structure) allow for a more cohesive and arguably more efficient legislative process. This is because the government is mainly drawn from the members of the majority party and the selection of the head of state (i.e. the prime minister in Canada and the chancellor in Germany) reflects his/her pre-eminent position within the party. In France however, the president is the head of state and, along with members of the Senate and Assembly, is directly chosen by the country's electorate. This can result in a "cohabitation" government wherein the president is not a member of the majority party and thus must cobble together effective alliances in order to govern. Nevertheless, the general cohesiveness of the majority party structure of the parliamentary system allows for a more streamlined approach and arguably a less contentious legislative process. Reform measures are more easily passed in European and Canadian parliaments as bills proposed by government ministers are almost always supported by their party peers in the legislature. In addition, the provisions for the dissolution and election of parliament preclude the kind of

functional gridlock and tortuous legislative process that can characterize the U.S political system. In contrast, the lack of term limits and the gerrymandering of Congressional districts has served to entrench the status quo on Capital Hill. Longevity in office translates into seniority and power on the Congressional committees which in turn control much of the legislative process and the future of such measures as health reform bills. When coupled with the American two party system, a structural polarization has been engendered that perseverates ideological turf wars and quashes compromise and legislative action. Hence it has been increasingly difficult to build consensus on innovative issues such as healthcare reform.

In addition to the federal obstacles that have affected healthcare reform, individual states have had a vested interest in the debate and have resisted/opposed measures that would encroach upon their authority to regulate insurance products and/or their autonomy to determine healthcare entitlements to their residents. Differing demographics, regulatory structures, political outlooks and economic resources amongst the states has resulted in significant variation in both healthcare and insurance protections and services from state to state. While states have been first movers in introducing healthcare reforms for their residents, the idiosyncratic nature of their programs have created inherent inequities for U.S citizenry as a whole. States that have implemented progressive reforms have pushed back against federal measures that would undermine their programs. Similarly, states who have taken a hands-off approach towards reform have vigorously opposed any imposed federal initiatives.

The U.S. is often characterized by its spirit of individualism and self-reliance. Its free market mindset has produced the world's strongest economy and an aversion to government controls. Such attributes could have been expected to produce a healthcare financing and delivery model that is innovative, effective and efficient. Instead a piecemeal, largely for-profit and often inequitable model has remained entrenched for decades. The main reason the U.S. has struggled (and continues to struggle) with its healthcare model is that we have has failed to define the core nature of its value within our society. In other words, we have failed to establish healthcare as a specific construct within the hierarchy of our national cultural norms. Thus, we have not concluded whether it is a commodity, a common good or a fundamental human right.

Since there was no higher context to place healthcare into, it has defaulted to commodity status throughout most of the 20th century and now into this one. This is why it was acceptable for market forces to be allowed to determine who would be allowed access to healthcare and who would not. Commoditizing healthcare permitted it to be sold for a profit, even if that profit was made off the suffering of those who purchased it. Lastly, the commoditization of healthcare fostered the development of certain institutions (i.e. insurance companies) which have actively fought any attempt to reform healthcare so as to serve their own self-interests.

Healthcare should rightly be seen as a fundamental human right. Other societies and governments have recognized it as such and have thus financed it as a public good. It is surprising therefore, that the U.S. has failed for so long to inculcate this value into its societal norms given that one of its founding documents speaks of

inalienable rights to “life, liberty and the pursuit of happiness”. Surely access to healthcare is interwoven with this right to “life” just as relief from medical costs is to the “pursuit of happiness”. The U.S. is one of only two countries (Somalia is the other) that have not ratified the treaty on The Rights of the Child which contains specific obligations to ensure healthcare standards for children.[105]

Viewing healthcare as a right ensured by the government would place it in the same context as public education. Using this perspective, the role of employer as the arbiter of the right to healthcare access seems absurd when juxtaposed against our right to public education. For example, employers do not choose the classes a child will be able to take nor do they select the school a child may attend. Yet in our current health care model employers will still have considerable control over what services will be covered and the insurance type that will be used to access this service.

Framing healthcare reform as a right rather than predominately as an economic issue would change the lens though which we view its financing. It would precipitate a restructuring of the current financing model away from segregated government and private sectors into an integrated approach. Resources would be pooled and distributed equitably as it is with other public goods. There would be no need to have separate insurance types to cover the poor (Medicaid) or elderly/disabled (Medicare). Instead, everyone would have the same comprehensive benefit package that could be customized with supplemental insurance at the option of the subscriber.

Lastly, if we amend the paradigm to value healthcare as a right, then we also fundamentally alter our view of the rights of children. Thus if the right to healthcare

is a fundamental one, then it applies to everyone regardless of age. The new model would emancipate children from dependence on insurance coverage through a parent's plan. They would be autonomously entitled to universal and equitable coverage that would be financed as a public good, and which in turn, would serve as an affirmation of our founding values.

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